MEMORANDUM

Agenda Item No. 5(B)

(Public Hearing: 9-1-21)

TO: Honorable Chairman Jose "Pepe" Diaz and Members, Board of County Commissioners

DATE: July 20, 2021

FROM: Geri Bonzon-Keenan
County Attorney

SUBJECT: Ordinance relating to the Medicaid Hospital Directed Payment Program; creating article IV of chapter 18 of the Code; providing for the imposition, levy, collection and enforcement of a mandatory payment to fund the non-federal share of Medicaid and Medicaid Managed Care payments to benefit existing and newly licensed hospital properties; identifying services to be provided

Ordinance No. 21-81

The accompanying ordinance was prepared and placed on the agenda at the request of Prime Sponsor Senator René García, and Co-Sponsors Chairman Jose "Pepe" Diaz, Vice-Chairman Oliver G. Gilbert, III, Commissioner Joe A. Martinez, Commissioner Raquel A. Regalado and Commissioner Rebeca Sosa.

Geri Bonzon-Keenan
County Attorney

GBK/smm

MEMORANDUM
(Revised)

TO: Honorable Chairman Jose "Pepe" Diaz
and Members, Board of County Commissioners

DATE: September 1, 2021

FROM: Geri Bonzon-Keenan
County Attorney

SUBJECT: Agenda Item No. 5(B)

Please note any items checked.

_____	**"3-Day Rule" for committees applicable if raised**
_____	**6 weeks required between first reading and public hearing**
_____	**4 weeks notification to municipal officials required prior to public hearing**
_____	**Decreases revenues or increases expenditures without balancing budget**
_____	**Budget required**
_____	**Statement of fiscal impact required**
_____	**Statement of social equity required**
_____	**Ordinance creating a new board requires detailed County Mayor's report for public hearing**
✓	**No committee review**
_____	**Applicable legislation requires more than a majority vote (i.e., 2/3's present ____, 2/3 membership ____, 3/5's ____, unanimous ____, CDMP 7 vote requirement per 2-116.1(3)(h) or (4)(c) ____, CDMP 2/3 vote requirement per 2-116.1(3)(h) or (4)(c) ____, or CDMP 9 vote requirement per 2-116.1(4)(c)(2) ____) to approve**
_____	**Current information regarding funding source, index code and available balance, and available capacity (if debt is contemplated) required**

Approved _____ Mayor
Veto _____
Override _____

Agenda Item No. 5(B)
9-1-21

ORDINANCE NO. 21-81

ORDINANCE RELATING TO THE MEDICAID HOSPITAL DIRECTED PAYMENT PROGRAM; CREATING ARTICLE IV OF CHAPTER 18 OF THE CODE OF MIAMI-DADE COUNTY, FLORIDA; PROVIDING FOR THE IMPOSITION, LEVY, COLLECTION AND ENFORCEMENT OF A MANDATORY PAYMENT TO FUND THE NON-FEDERAL SHARE OF MEDICAID AND MEDICAID MANAGED CARE PAYMENTS TO BENEFIT EXISTING AND NEWLY LICENSED HOSPITAL PROPERTIES; IDENTIFYING SERVICES TO BE PROVIDED; PROVIDING FOR SEVERABILITY, INCLUSION IN THE CODE AND AN EFFECTIVE DATE

WHEREAS, this Board desires to accomplish the purposes outlined in the accompanying memorandum, which is incorporated herein by reference,

BE IT ORDAINED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA:

Section 1. This Board incorporates, approves and adopts the foregoing recital as if fully set forth herein.

Section 2. Chapter 18, Article IV of the Code of Miami-Dade County, Florida is hereby created to read as follows:

ARTICLE IV. - HOSPITAL MANDATORY PAYMENTS

Sec. 18-50 – Definitions.

As used in this article, the following words and terms shall have the following meanings, unless the context shall indicate otherwise:

Board means the Board of County Commissioners of Miami-Dade County, Florida, as constituted under and pursuant to the Home Rule Charter of the County.

County means the unincorporated and incorporated areas of Miami-Dade County, Florida.

Fiscal Year means the period commencing on October 1 of each year and continuing through the next succeeding September 30, or such other period as may be prescribed by law as the fiscal year for the County.

Institutional Health Care Provider means a private for-profit or not-for-profit licensed hospital that provides inpatient hospital services.

Mandatory Payment means a payment imposed to fund the non-federal share of Medicaid and Medicaid managed care payments to benefit Properties.

Mandatory Payment Resolution means the resolution, which shall be the final proceeding for the imposition of a mandatory payment, establishing the rate for the mandatory payment for a specific Fiscal Year.

Medicaid Hospital Directed Payment Program means the program authorized by the Centers for Medicare & Medicaid Services (CMS) allowing Florida to direct specific payments made by managed care plans to all hospital providers for Medicaid services.

Property or Properties means those parcels on which an Institutional Health Care Provider within the County limits is situated and licensed, thus making it subject to the Mandatory Payment.

Property Owner means the legal title holder(s) of a Property or Properties.

Sec. 18-51 – Authority.

Pursuant to the Florida Constitution, Miami-Dade County Home Rule Charter, Chapter 125 of the Florida Statutes, Florida legislative and other administrative authority, and 42 CFR § 433.68, the Board is hereby authorized to impose a Mandatory

Payment pursuant to the Medicaid Hospital Directed Payment Program without the necessity of creating and establishing under the provisions of this chapter a special district.

Sec. 18-52 – Purposes, use, and services for which Mandatory Payments imposed.

Institutional Health Care Providers within the County incur hundreds of millions of dollars in unreimbursed Medicaid costs each year. Contingent upon the nonfederal share being provided through intergovernmental transfers, the State of Florida received federal authority to establish the Statewide Medicaid Managed Care hospital directed payment program to help offset this shortfall. The Mandatory Payments will, through intergovernmental transfers provided consistent with federal guidelines that the Mandatory Payment extend to all providers in Miami-Dade County, support additional funding for Medicaid payments to Institutional Health Care Providers to address the Medicaid shortfall and benefit the Properties.

The Mandatory Payments authorized by this article shall be imposed, levied, collected, and enforced against Property Owners and the Institutional Health Care Providers located within the County. The County services to be provided will consist of collecting the Mandatory Payments eligible for federal matching, creation of a local participation pool and trust fund, collection, deposit and subsequent transfer of such funds through intergovernmental transfers to the State of Florida in accordance with federal and state program requirements. An amount greater than or equal to the Mandatory Payments paid shall be used for capital improvements associated with performing services on the affected Properties and which enhance the use and enjoyment of such Properties. Permissible capital improvement projects include, but are not limited to, the purchase of medical equipment, fixtures and supplies, enhanced internal security, debt service, buildings, additions to buildings and internal improvements to buildings and facilities, infrastructure (e.g., plumbing electrical, windows, internal roads, parking facilities, lighting, flooring, and roofing), landscaping, capital maintenance and other costs associated with capital improvement projects relating to the provision of hospital services including Medicaid services. The Mandatory Payment shall be computed and imposed only in the manner provided in this article.

The County Mayor or County Mayor's designee is authorized to execute any agreements, as required by the Florida Agency for Health Care Administration or the federal government in connection with the Medicaid Hospital Directed Payment Program, following approval by the County Attorney's Office as to legal sufficiency.

Sec. 18-53 – Annual Proceedings for Imposing the Mandatory Payment.

The Board, subject to the provisions of this section and upon a petition requesting the imposition of the Mandatory Payment, signed by at least 75 percent of the Property Owners and Institutional Health Care Providers within the County and without an election, may impose a Mandatory Payment for the purposes provided for in this article. The proceedings for imposing the Mandatory Payment shall be as follows:

(a) *Petition*. For each fiscal year the Petition shall set forth: (1) the boundaries or other description sufficient to identify the Properties; (2) a brief description of the service requested to be provided; (3) a legal opinion, that is acceptable to the County Attorney's Office, from a duly licensed Florida attorney stating that the imposition of the Mandatory Payment is lawful; and (4) an executed release, in a form acceptable to the County Attorney's Office, wherein the Property Owner(s) and Institutional Health Care Providers state, among other things, that it forever releases the County and its officers, employees, and agents from any and all liability relating to the imposition of the Mandatory Payment. There shall be attached to the petition and made a part thereof a brief description of the Property sufficient to identify the property involved. There shall also be filed with the petition a duly certified copy of the proceedings of the board of directors or stockholders of the Property Owners and Institutional Health Care Providers and such other documents, if any, as may be required by the County Attorney to show that those signing the petition are duly authorized to sign the petition and to subject the Property to the levy and imposition of the Mandatory Payment as provided in this article.

(b) *Review*. Upon receipt of any such petition, the Clerk of the Board shall transmit one copy to the County Mayor and one copy to the County Attorney, each of whom shall examine the petition. If the County Attorney shall find that the petition has been properly signed and complies with the requirements of this section,

the County Mayor or County Mayor's designee is directed to cause by first class mail a notice of proposed Mandatory Payment to be sent to all Property Owners and the Institutional Health Care Providers. Such notice shall include, but not be limited to:

(1) The purpose of the Mandatory Payment;
(2) The Mandatory Payment rate to be imposed;
(3) The unit of measurement applied to determine the Mandatory Payment;
(4) The total revenue to be collected by the County from the Mandatory Payment; and
(5) A statement that all Property Owners and the Institutional Health Care Providers have a right to file a written objection, for good cause, with the County Mayor within 20 days of receipt of the notice. Notice shall be deemed mailed upon delivery thereof to the possession of the United States Postal Service. The County Mayor or County Mayor's designee may provide proof of such notice by affidavit. Failure of the Property Owners and the Institutional Health Care Providers to receive such notice, due to mistake or inadvertence, shall not affect the validity of the Mandatory Payment or release or discharge any obligation for payment of the Mandatory Payment imposed by the Board pursuant to this article.

In the event that one or more of the Property Owners and the Institutional Health Care Providers files a written objection stating good cause to the Mandatory Payment with the County Mayor within 20 days of receipt of the notice, the County Mayor or County Mayor's designee shall not prepare the preliminary Mandatory Payment roll for the Fiscal Year. If at any time one or more of the Property Owners or Institutional Health Care Providers files an objection to the Mandatory Payment, the Board's authority to collect the Mandatory Payments under this article shall be ineffective.

(c) *Preliminary Mandatory Payment roll*. If no Property Owners and the Institutional Health Care Providers file a written objection stating good cause to the Mandatory Payment as provided for in this article, the County Mayor or County Mayor's designee shall cause to be prepared and filed with the Clerk one preliminary Mandatory Payment roll. The preliminary Mandatory Payment roll shall contain:

(1) The names of all Property Owners and the Institutional Health Care Providers and a description of the Property;
(2) The total cost of the service; and
(3)The rate and amount of the Mandatory Payment to be imposed against each Property based on the Mandatory Payment Resolution.

The preliminary Mandatory Payment roll shall be retained by the Clerk of the Board and shall be open to public inspection. The foregoing shall not be construed to require that the roll be in printed form if the amount of the Mandatory Payment for each Property can be determined by use of a computer terminal available to the public.

(d) *Mandatory Payment Resolution*. The Mandatory Payment Resolution shall describe (a) the Medicaid payments proposed for funding from proceeds of the Mandatory Payment; (b) the benefits to the Properties associated with the Mandatory Payment; (c) the methodology for computing the Mandatory Payment amounts; and (d) the method of collection, including how and when the Mandatory Payment is to be paid.

(e) *Public notice.* Upon the filing with the Clerk of the Board of the preliminary Mandatory Payment roll required by this section, the Clerk shall publish once in each of two successive weeks in a daily newspaper of general circulation published in the County, a notice stating that a regular or special meeting of the Board to be held on a certain day and all Property Owners and the Institutional Health Care Providers may appear and file written objections, for good cause, to the confirmation of such roll. Such notice shall state the service being provided. Copies of such notice shall also be mailed to all of the Property Owners and the Institutional Health Care Providers which are to be subject to the Mandatory Payment. The first of such publications and mailing shall occur not less than 15 days prior to the date fixed for such hearing. One or more rate setting hearings may occur within a Fiscal Year. In the event there are additional rate setting hearings in a Fiscal Year, public notice for each hearing shall be as provided above.

(f) *Hearing and Confirmation of Mandatory Payment Roll.* At the time and place stated in such notice, the Board shall meet and receive the objections in writing of all interested persons as stated in such notice. The Board may adjourn the hearing from time to time. After the completion thereof the Board shall either annul or

sustain or modify in whole or in part the prima facie Mandatory Payment as indicated on such roll, either by confirming the prima facie Mandatory Payment described therein, or by canceling, increasing, or reducing the same, according to the special benefits which the Board decides each such Property has received or will receive on account of such service. If the Mandatory Payment which may be chargeable under this section shall have been omitted from the preliminary roll or if the prima facie Mandatory Payment shall not have been made against it, the Board may place on such roll an apportionment to such Property. The Board shall not confirm any Mandatory Payment in excess of the special benefits to the Property, and the Mandatory Payments so confirmed shall be in proportion to the special benefits. After such confirmation, the Mandatory Payment roll shall be delivered to the Finance Director of the County. The Mandatory Payments so made shall be final and exclusive as to each Property unless proper steps be taken within 10 days in a court of competent jurisdiction to secure relief. If the Mandatory Payment against any property shall be sustained or reduced or abated by the court, the Finance Director shall note that fact on the Mandatory Payment roll opposite the name of the Property Owner and the description of the Property affected thereby.

Sec. 18-54 – Scope, computation, and administrative costs of Mandatory Payment.

(a) *Scope*. The Mandatory Payment must be broad-based, and the amount of the Mandatory Payment must be uniformly imposed on each Property. The Mandatory Payment may not hold harmless any Institutional Health Care Provider, as required under 42 U.S.C. § 1396b(w). Unless paid when due, the Mandatory Payment shall be deemed delinquent, and payment thereof may be enforced in accordance with applicable law.

(b) *Computation*. The annual Mandatory Payment shall be specified. The Board shall set the Mandatory Payment in amounts that in the aggregate will generate sufficient revenue to fund the non-federal share of Medicaid payments to be funded by the Mandatory Payment. The amount of the Mandatory Payment required of each Property Owner may not exceed an amount that, when added to the amount of assessments levied by the state or local government, exceeds the maximum percent of the aggregate net patient revenue of all Properties in the County permitted by 42 C.F.R. § 433.68(f)(3)(i)(A). Mandatory Payments for each

Property Owner will be derived from data contained in hospital cost reports and/or data in the Florida Hospital Uniform Reporting System, as available from the Florida Agency for Health Care Administration. Institutional Health Care Providers shall be responsible for timely providing hospital cost reports, data in the Florida Hospital Uniform Report System, or any other data or information necessary in the County's sole discretion to perform computations in connection with the Mandatory Payments required in this article.

(c) *Administrative costs*. Creation and implementation of the Mandatory Payments will not result in any additional pecuniary obligation on the County, Board, or County residents as the Mandatory Payments shall be imposed, levied, collected, and enforced against only the Property Owners, and the Mandatory Payment Resolution shall provide that the County's administrative costs shall be reimbursed from the collected amounts on a pro rata basis from the Property Owners.

Sec. 18-55 - Local provider participation trust fund.

All moneys received under the provisions of this article shall be held in a trust fund, created by the County applied solely (1) for the Medicaid Direct Payment Program, and (2) to reimburse the County for administrative costs associated with the implementation of the Mandatory Payment authorized by this article, as further specified in the Mandatory Payment Resolution. Any officer to whom, or any bank, trust company or other fiscal agent or trustee to which such moneys shall be paid shall act as trustee of such moneys and shall hold and apply the same for the purposes of this article.

Sec. 18-56 - Method of collection.

The County Mayor or County Mayor's Designee shall provide the Mandatory Payment bills by first class mail to each Property Owner and Institutional Health Care Provider. The bill or accompanying explanatory material shall include:

(1) A brief explanation of the Mandatory Payment;
(2) A description of the unit of measurement used to determine the amount of the service;
(3) The number of units contained within the Mandatory Payment;

(4) The total amount of the Mandatory Payment imposed against the Property for the appropriate period;
(5) The location at which payment will be accepted;
(6) The date on which the Mandatory Payment is due;
(7) A statement regarding the potential consequences for failure to timely pay the Mandatory Payment; and
(8) A copy of the indemnification required by section 18-62, which shall be executed by the Institutional Health Care Provider and returned with the submission of the Mandatory Payment.

Sec. 18-57 - Refunds.

If, at the end of the Fiscal Year, additional amounts remain in the local provider participation trust fund, the Board is hereby authorized to make refund to Property Owners, in proportion to amounts paid in during the Fiscal Year, for all or a portion of the unutilized local provider participation trust fund.

Sec. 18-58 - Responsibility for Enforcement.

The County and its agent, if any, shall maintain the duty to enforce the prompt collection of the Mandatory Payment by the means provided herein. The duties related to collection of Mandatory Payments may be enforced at the suit of any holder of obligations in a court of competent jurisdiction by mandamus or other appropriate proceedings or actions.

Sec. 18-59 - Correction of Errors and Omissions.

No act of error or omission on the part of the Board, County Mayor or County Mayor's designee shall operate to release or discharge any obligation for payment of the Mandatory Payment imposed by the Board under the provision of this Chapter.

Sec. 18-60. – **Limitations on Mandatory Payment.**

This Mandatory Payment is authorized only based on the approval by CMS, and related authorization by Florida Legislature, of the directed payment program that will benefit the Property Owners, Institutional Health Care Providers, and Properties. If at any time, due to action at the federal, state or local level, there is no longer an enhanced Medicaid payment benefitting the Property Owners, Institutional Health Care Providers, and Properties in the County, the Board's authority to collect Mandatory Payments under this

article shall cease. If, at any time, the Mandatory Payments are no longer broad-based, the Board's authority to collect Mandatory Payments under this article shall be ineffective. If at any time one or more of the Property Owners or Institutional Health Care Providers objects to the Mandatory Payment, the Board's authority to collect the Mandatory Payments under this article shall cease.

Sec. 18-61 - Limitations on Surcharges.

Mandatory Payments made by Property Owners or Institutional Health Care Providers under this article may not be passed along to patients of the Institutional Health Care Providers as a surcharge or as any other form of additional patient charge.

Sec. 18-62 - Hold Harmless and Indemnification.

The Institutional Health Care Providers and Property Owners that are the subject of this article have requested adoption of this article and have given assurances to the County that the objectives and procedures addressed in this article are proper and lawful. Accordingly, the Institutional Health Care Providers and Property Owners that are the subject of this article shall hold the County and its officers, employees, and agents harmless from any claim arising from the adoption and implementation of this article, and shall indemnify the County and its officers, employees and agents from any and all claims, suits, damages, disallowances, or other proceedings, including but not limited to original proceedings, appeals, or any proceeding before any administrative body or tribunal, costs and attorney or expert fees associated with the defense of such claims, that may arise in the event that the objectives and procedures of this article are challenged by any person, entity, or government agency. This indemnification and hold harmless shall be approved by the Office of the County Attorney as to legal sufficiency, and shall be submitted with the Mandatory Payment pursuant to section 18-56(8).

Section 3. A duly certified copy of this Ordinance shall be filed in the Office of the Clerk of the Circuit Court of Miami-Dade County, Florida, and recorded in the appropriate book of records.

Section 4. If any section, subsection, sentence, clause or provision of this ordinance is held invalid, the remainder of this ordinance shall not be affected by such invalidity.

Section 5. It is the intention of the Board, and it is hereby ordained that the provisions of this Ordinance shall be included and incorporated in the Miami-Dade County Code, as an addition or amendment thereto, and shall be appropriately renumbered to conform to the uniform numbering system of the Miami-Dade County Code, once established.

Section 6. The provisions of this Ordinance shall become effective ten days after the date of its enactment, unless vetoed by the Mayor, and if vetoed, shall become effective only upon an override by this Board.

PASSED AND ADOPTED: September 1, 2021

Approved by County Attorney as
to form and legal sufficiency:

Prepared by:

Jorge Martinez-Esteve
Christopher C. Kokoruda

Prime Sponsor: Senator René García
Co-Sponsors: Chairman Jose "Pepe" Diaz
Vice-Chairman Oliver G. Gilbert, III
Commissioner Joe A. Martinez
Commissioner Raquel A. Regalado
Commissioner Rebeca Sosa

Memorandum

Date: July 20, 2021

To: Honorable Chairman Jose "Pepe" Diaz
and Members, Board of County Commissioners

From: Daniella Levine Cava Mayor

Subject: Ordinance Related to the Medicaid Hospital Directed Payment Program

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Recommendation

It is recommended that the Board of County Commissioners (Board) approve an ordinance creating Article IV of Chapter 18 of the Code of Miami-Dade County (Code) relating to the Medicaid Hospital Directed Payment Program. This ordinance will authorize the Board to impose, levy, collect, and enforce a mandatory payment against private for-profit or not-for-profit hospitals that provide inpatient hospital services within the County. It is unnecessary to create and establish a special district under the provisions of Chapter 18 to impose this mandatory payment.

Scope

This proposed mandatory payment is countywide, but it affects only private, for-profit or not-for-profit hospitals and their respective properties. The affected hospital properties are located throughout multiple County Commission Districts, which are represented by several County Commissioners.

Fiscal Impact/Funding Source

Creation of this mandatory payment will result in no economic impact to the County budget and no increase or decrease in County staffing. The funds collected via the mandatory payment will reimburse all costs incurred by the County for the creation and administration of the mandatory payment.

Social Equity Statement

The creation of this directed payment program, the affected hospitals requested, will allow generation of federal matching dollars—a result that benefits the affected hospital properties by improving income potential and by providing funds available for investment in capital improvements. The proposed ordinance authorizes the mandatory payments pursuant to the Florida Constitution, Miami-Dade County Home Rule Charter, Chapter 125 of the Florida Statutes, and 42 CFR § 433.68. If approved, hospital property owners affected by the mandatory payments will make payments appropriately apportioned according to the special benefit they receive from the resultant service, regardless of their demographics. The total estimated amount of the mandatory payments to be levied will not exceed the benefits each owner will receive from the service provided. Pursuant to the applicable federal regulations, this service can only be provided by the County, and only by the County requiring all hospitals in the relevant class of health care facilities to pay a fee or other mandatory payment.

Track Record/Monitor
The mandatory payments will be managed by the Finance Department's Credit and Collections unit and monitored by Ms. Cristina Mekin, Section Manager.

Delegation of Authority
This item authorizes the County Mayor or County Mayor's designee to execute any agreements required by the Florida Agency for Health Care Administration (AHCA) or the federal government to implement the intergovernmental transfers or other components of the program, subject to approval by the County Attorney's Office as to form and legal sufficiency.

Background
Medicaid is a joint federal-state health insurance program that provides medical coverage to a low-income population consisting of children, pregnant women, people over 65, and individuals with disabilities. *See* 42 U.S.C. § 1396, et seq. Although the program is administered by the states, Medicaid is jointly funded by states and the federal government through federal matching of state funds. *See* 42 U.S.C. § 1396b.

State general revenue comprises a large share of the funds receiving a federal match. Other forms of revenue collection, however, also qualify for matching. For example, local governments can collect funds and use intergovernmental transfers (IGTs) to send those funds to the state for federal matching. *See* Social Security Act § 1902(a)(2); 42 CFR § 433.51. IGTs have the advantage of increasing the magnitude of federal spending without a commensurate increase in state general revenue spending. So long as the collection of funds and these IGTs comply with federal rules, they are eligible for federal match. *See* Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, PL 102–234, December 12, 1991, 105 Stat. 1793; Social Security Act § 1903(w).

Medicaid payments funded by federal matching serve a vital public purpose. Hospitals that provide Medicaid services or other forms of indigent care often fail to receive full compensation for those services. Indeed, the Florida Hospital Association recently estimated that Medicaid reimbursement equates to approximately 66 percent of total procedure costs, leaving hospitals with 34 percent of costs unreimbursed. This gap, known as the "Medicaid shortfall," results in $2.3 billion in uncompensated Medicaid costs incurred by Florida hospitals each year.

In Miami-Dade County, the problem is dire. The County metropolitan area includes approximately 17% of Florida's Medicaid enrollees. Hospitals in Miami-Dade County annually provide $524 million in unreimbursed Medicaid services to persons who qualify for Medicaid. State Medicaid Managed Care Region 11, which includes Miami-Dade County, alone accounts for 23% of the total $2.3 billion shortfall borne by the state's hospital providers. Addressing the shortfall is a critical need.

Recent events position Miami-Dade County to take action to address the shortfall faced by local hospitals. On April 26, 2021, the federal Centers for Medicare & Medicaid Services (CMS)

approved a pre-print application submitted by AHCA, the State Medicaid agency, for a new payment program that can provide direct federal payments to local hospitals. This directed payment program will provide a uniform increase in Medicaid managed care rates for Florida hospitals that deliver certain inpatient and outpatient services. This increase will address the Medicaid shortfall faced by each hospital in Florida. The funds received through the program will offset the $524 million in uncompensated Medicaid costs that Miami-Dade County hospitals incur each year. To succeed, the program requires the State to contribute a non-federal share that will be eligible for federal match.

The proposed ordinance intends to impose a mandatory payment on the eligible hospitals, a form of provider tax permissible under 42 CFR § 433.55 ("A health care-related tax is a licensing fee, assessment, or other mandatory payment …"). From the federal perspective, such payments would qualify for federal match because they are mandatory, broad based, and uniformly imposed on private hospitals in the jurisdiction. 42 CFR § 433.68.

The County services to be provided will consist of collecting the mandatory payments eligible for federal matching and remitting such funds through intergovernmental transfers. That service will unlock directed payment program funds from the federal government that would be unavailable if the County did not provide this service. The resultant subsidy benefits Miami-Dade County hospital properties through enhanced Medicaid payments, which may be used for capital projects related to the provision of healthcare services such as Medicaid. Contingent upon Board approval of this ordinance, the services will be accomplished pursuant to an agreement between the County and AHCA. The County, through its designated agent, will administer the billing process.

The mandatory payments involve a local government service that confers a specific, direct benefit to the payors, and this benefit also extends to the value of the hospital properties themselves.

1. The payors that will pay the mandatory payment will derive a special benefit from the service provided by the County.

As provided in the July 18, 2021 report prepared by Mr. Lucas Woodruff from OHC Heathcare property advisors, hospitals, and hospital properties, that are eligible for increased federal funds from the directed payment program are more valuable than similar hospital operations and properties that do not receive these funds. A copy of this report is Exhibit 1 to this memorandum. In addition, hospital operations and properties eligible for the increased federal match are more valuable than their non-qualifying counterparts in neighboring districts without such mandatory payments. When hospital systems seek to expand into Florida or a given region of the state or consider whether to stay, they will target lands in counties that impose the payments and offer the federal match. Desire for such lands will drive up their value, just as provision of certain services, such as fire protection or waste management, do. Moreover, an amount of funding greater than or equal to the mandatory payments paid must be used for capital improvements associated with performing services on the affected properties and which enhance the use and enjoyment of such properties. In addition, the payors receive a special benefit by receiving a greater level of Medicaid

reimbursement, and thereby reduce their shortfall from providing unreimbursed medical services, than they would otherwise be able to obtain without this direct payment program.

2. The mandatory payment is also fairly and reasonably apportioned.

As provided in the July 11, 2021 report prepared by Jason Durrett, Director of Finance at Adelanto Health Care Ventures, the mandatory payment rate will be rooted in data from hospital cost reports, the Florida Hospital Uniform Reporting System, or both, as available from AHCA. The rate will be determined based on a proxy for utilization, such as net patient revenue. The resultant payment distributed to the payors will provide a uniform percentage increase to the base health plan payments made to eligible hospitals properties for inpatient and outpatient services provided to Medicaid managed care enrollees. Such benefit will be specified for each payor and will be fairly and reasonably apportioned. The Durrett report further outlines the step-by-step mandatory payment rate setting process. Finally, the Durrett report estimates that the direct payment program would provide an additional $306 million to Miami-Dade County hospitals, which represents the local share of the statewide Medicaid shortfall. A copy of this report is Exhibit 2 to this memorandum. Furthermore, Section 18-54 of the proposed ordinance further provides how the mandatory payment will be computed.

Upon Board approval, eligible hospitals may file a petition with the Clerk of the Board requesting the imposition of the mandatory payments without an election. If one or more of the eligible hospitals file a written objection to the mandatory payment, the payment will not be imposed for that fiscal year. The proposed ordinance includes an indemnification provision and a requirement that petitioning property owners submit a release.

Edward Marquez
Chief Financial Officer

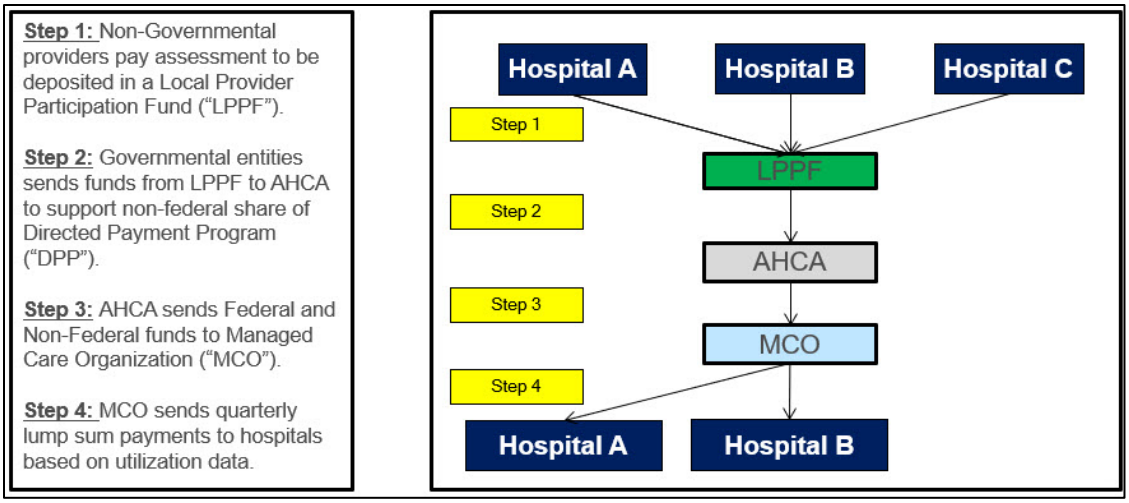
My name is **Lucas Woodruff**, MAI. I'm an appraiser and Partner, EVP – Acute Care at the valuation firm OHC Advisors. OHC Advisors specializes in the valuation of healthcare properties and I lead the acute care side of the business. Over the course of my career, I have appraised well over 200 hospitals in addition to medical office buildings, behavioral health facilities, psychiatric hospitals and surgery centers. I received my designation as a member of the Appraisal Institute (MAI) in 2016 which is a designation long recognized by courts of law, government agencies, financial institutions and investors as a mark of excellence in the field of real estate valuation and analysis.

This letter concerns the impact of a new Medicaid finance program operating in Florida. Medicaid was enacted by the federal government in 1965, as part of the Social Security Amendments. Medicaid provides healthcare coverage for the nation's most economically disadvantaged populations, as well as the nations disabled. The program is jointly administered and funded by the federal government and states.

Florida recently received approval from the federal government to implement the Medicaid Managed Care Hospital Direct Payment Program (Hospital DPP). This program allows the state to direct certain funds for a specific purpose. For the Hospital DPP, the purpose is addressing the Medicaid shortfall (i.e., the difference between the amount hospitals spend to provide Medicaid services and the amount they receive in reimbursement).

To implement the Hospital DPP, counties adopt a non-ad valorem special assessment to collect funds from hospitals. The counties transfer those funds to the state, where the money constitutes the non-federal share of Medicaid financing and, as a result, draws down additional federal funds. The sum is then dispersed to address the hospital Medicaid shortfall. The Hospital DPP results in increased net patient service revenue.

The exact amount of additional matching funds from the federal government via the Hospital Directed Payment Program (Hospital DPP) will vary but the projections provided to me via an impact analysis performed by Adelanto Healthcare Ventures, based on data from Florida Agency for Health Care Administration (AHCA), indicate it is roughly 160% of the initial assessment amount. The combined amount would then be dispersed throughout hospitals in the region after expenses of administrative fees and MCD DSH Loss (a reduction due to Medicaid Disproportionate Share Hospital Loss where there is a limit on the amount of Medicaid reimbursement for these facilities). The impact analysis and other supporting documents are available on request. The chart below provided by Adelanto Healthcare Ventures shows the general flow of funds from the hospitals, to the Local Provider Participation Fund (LPPF) to the State of Florida Agency for Health Care Administration (AHCA) who then gets the matching federal funds and sends them to the Managed Care Organization who disperses the funds to the hospitals.



Medicaid is funded by state and federal governments jointly with each covering a portion of the expense. The percentage of funding from the government is based on the income figures of the state in relation to the national averages. However, the rates paid are still below the actual costs of delivering the services resulting in a shortfall. Shortfall is calculated by taking hospital Medicaid costs and deducting Medicaid payments received from the state/federal government. According to the American Hospital Association (AHA) Medicare-Medicaid 2020 Underpayment Fact Sheet, the underpayment for Medicaid in 2019 was $19 billion and indicated hospitals received only 90 cents per every dollar spent caring for Medicaid patients in 2019. In Florida, according to the Florida Hospital Association Facts and Stats page, Medicaid represents 7.9% of total funding for all Florida hospitals. They also report that the cost of uncompensated care from all sources is approximately $2.8 billion. Florida has also seen a recent spike in Medicaid enrollment since the pandemic of approximately 20 percent indicating the shortfall issue will likely become a bigger one going forward. In addition, the most recent Florida budget from January of 2021 included a cut to Medicaid but did include authorization for a state directed provider payment program (DPP).

Based on my [training and experience] as an appraiser of medical facilities and specifically hospitals, it is my opinion that hospital properties that are eligible for increased federal funds from the Hospital DPP are more valuable than similar properties that do not receive these funds, all other factors equal. This is easily seen in the business enterprise/going concern value but the impact on the real estate can also be approximately quantified. Additionally, some counties require the initial assessment but used for capital improvements to the benefit of the real estate which helps ensure and increase to the value of the real estate.

Analysis

I was provided with sample numbers for a partial portion of an example Florida Medicaid Managed Care Region. The numbers represent actual health system data from AHCA data. The data is shown below:

Impact Analysis - Florida Medicaid Managed Care Region							
Example System	Gross Reimbursement	IGT Need (Assessment)	% Change	Net Reimbursement (before expenses)	Net Reimbursement (after fees and MCD DSH Loss)	Fee %	Net Gain over IGT Need (Assessment)
A	$7,052,258	$2,682,679	162.9%	$4,369,579	$4,274,770	-2.2%	59.3%
B	$6,090,752	$2,316,922	162.9%	$3,773,830	$3,395,076	-10.0%	46.5%
C	$28,253,220	$10,747,525	162.9%	$17,505,695	$16,948,922	-3.2%	57.7%
D	$412,058	$156,747	162.9%	$255,311	$39,863	-84.4%	-74.6%
E	$108,097	$41,120	162.9%	$66,977	$65,231	-2.6%	58.6%
F	$2,858,776	$1,087,478	162.9%	$1,771,297	$1,738,673	-1.8%	59.9%
G	$70,965,369	$26,995,226	162.9%	$43,970,142	$37,422,357	-14.9%	38.6%
H	$673,017	$256,016	162.9%	$417,001	$406,132	-2.6%	58.6%
Total or Average (percentages)	**$116,413,547**	**$44,283,713**		**$72,129,832**	**$64,291,024**	**-15.2%**	**38.1%**
					Average w/o outlier	**-5.3%**	**54.2%**

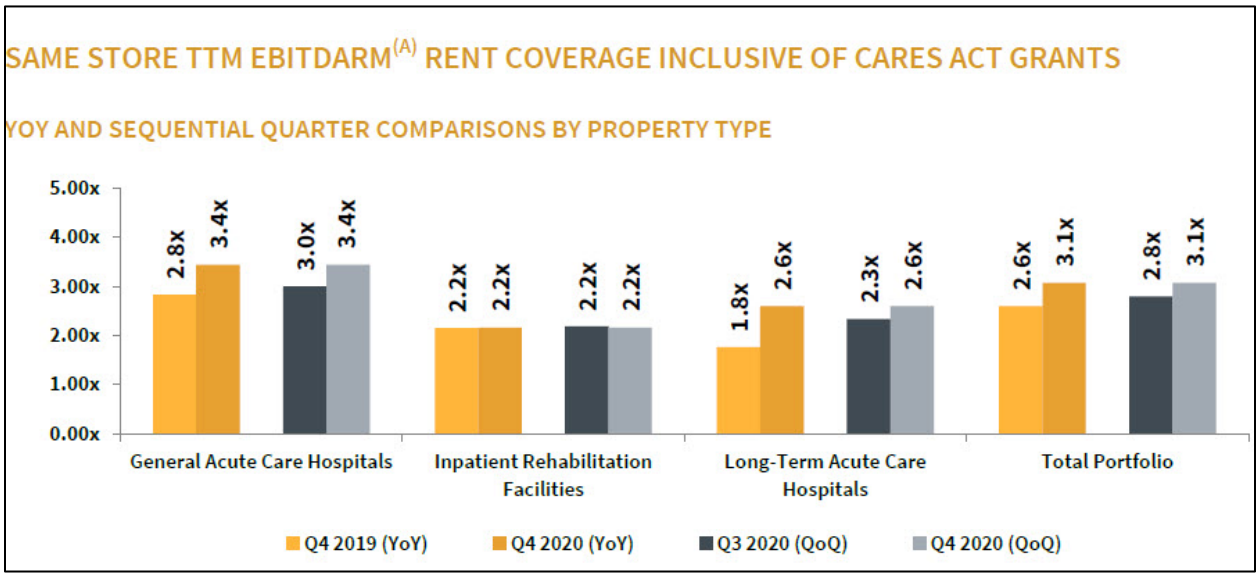
As shown, the IGT Need (Inter-governmental transfer) represents the amount of assessment on each hospital paid into the LPPF (Local Provider Participation Fund). This money is then sent to the Florida Agency for Healthcare Administration (AHCA) who then request the federal matching as shown on the earlier chart. In this analysis, the resulting funds after the federal match represent 162.9% increase over the initial assessment (Gross Reimbursement). These funds are then distributed out to the entire region. After the deduction of fees and MDC DSH Loss, there is still a net gain that averages 38.1% for the participating health systems (54.2% if we exclude the outlier). The disbursement of funds is based on Medicaid utilization data.

The additional funding would flow right through the income statement to both the net patient service revenue (NPSR) top-line number and, after operating expenses are deducted, eventually to the earnings before interest, taxes, depreciation, amortization and rent (EBITDAR) which are the primary numbers I use and have seen used in valuations of the going concern of hospitals, also known as business enterprise value. The going concern value (business enterprise value) is then broken down into real estate, FF&E (furniture, fixtures and equipment) with any residual as intangible value.

The relation of the operation revenue increase from DPP to the value of the real estate is a little more convoluted as the value of the real estate does not fluctuate as much from year to year with the large swings that sometimes occur in hospital revenue and EBITDAR numbers. That said, a continued and consistent increase in NPSR and EBITDAR would show up in the value of the real estate via the perspective of an investor in healthcare real estate. There are many public and private REITs (Real Estate Investment Trusts) that invest in healthcare real estate including hospitals, surgery centers, medical office buildings, seniors housing and other types of medical properties. These investors typically purchase the hospital real estate in a sale-leaseback transaction. This allows the health system to monetize the real estate and deploy that capital into hopefully more profitable service areas. The REIT will want to maximize their return on the investment by setting the highest lease rate possible and paying the lowest price while the health system will want the exact opposite. Many of the REITs will have minimum rent coverage ratios for any investments they consider. The rent coverage ratio is determined by the EBITDAR or EBITDARM (M

representing management fees) divided by the real estate lease/rent. The higher the result, the more safety the investment has that the tenant, in this case the hospital, will meet the rent commitment for the real estate.

One of the largest REITs that own acute care hospital real estate is Medical Properties Trust (MPT). They currently own the real estate for 62 general acute care hospitals The chart below is from their 1st quarter 2021 supplemental financial statements and shows the rent coverage ratio also called lease coverage ratio. The most recent rent coverage ratio is 3.4 for general acute care hospitals.



For this example, we will use a 2.5 minimum rent coverage ratio. The chart below includes real estate only sales of general community hospitals. The buyer is typically a REIT and there is either an existing lease in place or it is a sale-lease back transaction where we can determinate a capitalization rate (net operating income divided by the sale price). The rates range from 8.69% to 11.66% with a mean of 9.61%. The average real estate lease rate was $31.05 per square foot.

Real Estate Only Hospital Sale Comparables

Name	Location	Price	Date	GBA	Price Per GBA	Lease Rate per SF	Year Built	Capitalization Rate
WellStar North Fulton Regional Hospital	Roswell, GA	$82,039,856	2/19/2020	306,753	$267.45		1985	
Foundations El Paso Hospital	El Paso, TX	$32,000,000	10/31/2019	77,000	$415.58	$42.63	2003	11.66%
Southern Indiana Rehabilitation Hospital	New Albany, IN	$23,400,000	6/28/2018	64,380	$363.47	$32.71	1994	8.69%
City Hospital of White Rock	Dallas, TX	$23,284,000	3/8/2018	236,314	$98.53	$9.63	1976,88,94	9.34%
Great Bend Regional Hospital	Great Bend, KY	$24,500,000	3/31/2017	58,000	$422.41	$39.22	2009	8.75%
					Average	**$31.05**		**9.61%**

We spoke with the head of acquisitions/EVP/Chief Investment Officer for a private healthcare REIT who has been directly involved in the purchase and sales of many hospitals throughout the nation. He stated the primary impact of the increased reimbursement would be through the higher rent coverage ratio. He stated that the typical go, no-go rent coverage ratio for his firm and others was approximately 2.0. This is

assuming a market rate for the hospital real estate lease which are typically long-term (10 + years) and absolute net with the hospital operator paying all operating expenses related to the real estate. He stated that if the rent coverage ratio increased from say a 1.75 to a 2.25, it would attract far more interested buyers which would impact the value of the real estate. Additionally, moving above a 2.0 (and the higher the better) would allow for easier financing as the banks also have minimum lease coverage requirements and will offer better financing terms as the risk of default is lowered. Better financing terms can and do impact real estate values. As a result of these impacts, he estimated the capitalization rate could potentially be 25 basis points lower resulting in a higher real estate value. He also reiterated the difficulty of isolating the increase in operating income (EBITDAR) of the hospital entity to an increase in the value of the real estate as these transactions are property specific with many other variables to consider.

We will use an example with a theoretical lease rate as we do not know the exact details (size, lease rate, etc.) for any of the hospitals in the sample region from the Impact Analysis shown earlier, based on AHCA data. As shown on the chart below, the example hospital is 200,000 square feet with the average rental rate shown from our comparables above of $30.00 per square foot. We multiplied those for our effective gross income (EGI). Since almost all hospitals owned by REITs or other institutional real estate investors are long term and absolute net (tenant paying operating expenses), we did not deduct for vacancy and only deducted a nominal 2.5% of EGI for landlord expenses of a management fee and reserves to get our Net Operating Income (NOI).

Example Hospital of Potential Real Estate Value Increase	
Hospital Size (SF)	200,000
Annual Rental Rate per SF	$30.00
Effective Gross Income (EGI)	$6,000,000
NOI (using 2.5% operating expenses)	**$5,850,000**
EBITDAR using 1.75 LCR	$10,237,500
Increased EBITDAR due to DPP (using 2.25 LCR)	$13,162,500
Value using cap rate of 9.75% (NOI/.0975)	$60,000,000
Value using lower cap rate of 9.50% due to decreased landlord risk from DPP and increased investor interest (NOI/.095)	$61,578,947
Real Estate Value increase	**$1,578,947**

Once we have our NOI, we compare to the two different EBITDARs, one if the hospital does not participate in the Hospital Direct Payment Program and one example where the Lease Coverage Ratio is higher due to participation in the DPP resulting in a higher EBITDAR. We then use the different capitalization rates based on our comparables and discussions with the head of acquisitions for a healthcare private REIT. We again note that the higher LCR would result in a larger pool of interested buyers, it would also facilitate easier financing with better terms as well as more comfort/cushion for the buyer as well. Given these factors, a decrease in the capitalization rate of approximately 25 basis points would be warranted and that amount was also estimated by the chief investment officer at the healthcare REIT. Using the different

cap rates resulted in a value increase of $1,578,947 for the facility participating in the Hospital Direct Payment Program.

Capital Improvements

Additionally, the hospitals may also apply the additional revenue generated from participation in the program to further enhance their property value in the future through capital outlay projects including renovations and expansions. The additional funding via the DPP could allow these projects to occur more quickly and easily, adding to the real estate value or helping maintain that value via on-going repairs and maintenance.

In fact, in Miami Dade County the ordinance relating to the Medicaid Hospital Directed Payment Program requires that the money equivalent to the mandatory initial assessment must be allocated to capital improvement projects while the additional money can be spent however the hospital/health system chooses. An excerpt of the Miami-Dade County DPP Ordinance Article IV, Section 18-52 is shown below:

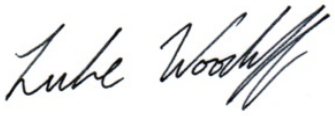
The Mandatory Payments authorized by this article shall be imposed, levied, collected, and enforced against Property Owners and the Institutional Health Care Providers located within the County. The County services to be provided will consist of collecting the Mandatory Payments eligible for federal matching, creation of a local participation pool and trust fund, collection, deposit and subsequent transfer of such funds through intergovernmental transfers to the State of Florida in accordance with federal and state program requirements. An amount greater than or equal to the Mandatory Payments paid shall be used for capital improvements associated with performing services on the affected Properties and which enhance the use and enjoyment of such Properties. Permissible capital improvement projects include, but are not limited to, the purchase of medical equipment, fixtures and supplies, enhanced internal security, debt service, buildings, additions to buildings and internal improvements to buildings and facilities, infrastructure (e.g., plumbing electrical, windows, internal roads, parking facilities, lighting, flooring, and roofing), landscaping, capital maintenance and other costs associated with capital improvement projects relating to the provision of hospital services including Medicaid services.

The county has specified a variety of ways the mandatory payment money can be used that will be considered capital improvements from expansions to infrastructure replacements to landscaping. This provision ensures another way in that real estate value would benefit. We note that not all of the listed items would directly increase the real estate value and some items on this list would be more beneficial to value than others. However, in general, capital improvements increase the value of the real estate, especially those that add additional square footage or renovate portions of the hospital. Replacing mechanical systems can also increase the value of the real estate but not to the same degree as larger renovations or expansions. In our opinion, we consider this provision in the ordinance a further way of ensuring that the real estate benefits from the program by requiring a portion of the money received (equivalent to the initial assessment) goes directly to capital improvements. Any expenditure that directly enhances the actual real estate whether through expansion, renovation, upgrades or necessary infrastructure replacements increases the value of said real estate.

Therefore, there is a direct, positive influence on the market value of the real estate for participating hospital properties due to the additional income generated from participation in this program as shown by the earlier example or through the direct use of funds for capital improvement projects that benefit the real estate.

Health Systems considering adding a new hospital would be more likely to choose a county that participates in this program given the impact to NPSR and EBITDAR of the operation and would likely pay more for land in an area/county that participated in the Direct Payment Program versus one that did not, all other things being equal.

Sincerely,



Lucas (Luke) Woodruff, MAI
Partner, EVP-Acute Care
OHC Advisors, Inc.

REPORT OF JASON DURRETT

Rate Setting and Operation of the Directed Payment Program for Private Hospitals in Miami-Dade County

I. Qualifications

My name is Jason Durrett. I am over twenty-one (21) years of age and competent to testify, and the facts stated herein are accurate to the best of my knowledge. I am the Director of Finance at Adelanto Health Care Ventures ("AHCV"). I have served in this role for over four years. I have 15 years of experience working in health care finance, including extensive experience with health care and hospital rate setting. My resume is attached as "Exhibit A."

II. Background

The State of Florida received approval from the Centers for Medicare & Medicaid Services ("CMS") to implement the Medicaid Managed Care Hospital Directed Payment Program ("DPP"). Through the DPP, the federal government allows Florida to implement a hospital payment program through the state's contracted Medicaid managed care organizations (MCOs). Specifically, the approved program allows for a uniform percentage increase to the base health plan payments made to eligible hospitals for inpatient and outpatient services provided to Medicaid managed care enrollees. The increased payments will be determined individually for each of Florida's 11 Medicaid managed care regions.

This Report will explain the DPP for private hospitals. In addition, this Report will also explain how the rate-setting process would work for Miami-Dade County, Florida's Medicaid managed care Region 11. This report and the data herein is provided for illustrative purposes only.

III. Data

To demonstrate how the rates are set for the DPP, I used source data gathered from publicly available 2019 Medicare cost reports.[1] I also use 2018 Medicaid claim data received from Florida Agency for Health Care Administration ("AHCA") to calculate the Medicaid shortfall and rate add-on. The source data is explained in detail below and attached in the referenced exhibits.

As explained in more detail below, the estimated statewide shortfall is $2.3 billion in total. Of the $2.3 billion, I estimate Region 11 would be eligible to receive $306 million in DPP for private hospitals.

IV. Program Steps and Rate-Setting Process

Step 1: The Florida Agency for Health Care Administration ("AHCA") determines the DPP pool size based on the Medicaid shortfall. Medicaid shortfall is determined by taking the difference between the amount Florida hospitals spend providing Medicaid services and the amount they receive in reimbursement.

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports

Based on my calculations using publicly available 2018 Medicaid data received from AHCA, I anticipate the statewide DPP pool will be around $2.3 billion for Program Year 1 (Oct. 2020 - Sept. 2021).

Step 2: AHCA allocates the DPP pool using the Medicaid shortfall total for each of Florida's 11 Medicaid managed care regions by hospital class. There are three hospital classes: public hospitals, private hospitals, and cancer hospitals.

The table below shows how the funds will be allocated for each hospital class in Region 11 assuming a $2.3 billion total statewide pool:

Managed Care Regions	Provider Class	Medicaid Shortfall	% Allocation of DPP Pool	$ Allocation of DPP Pool
11	Public	$ 217,271,643	9.3%	$ 217,271,643
11	Private	$ 299,663,573	12.9%	$ 299,663,573
11	Cancer	$ 7,104,547	0.3%	$ 7,104,547
State Totals		**$ 2,324,251,372**	**100%**	**$ 2,324,251,372**

Using the 2018 Medicaid data available from AHCA, I project that the private hospitals (i.e., Private and Cancer hospital classes) in and around Miami-Dade County face a Medicaid shortfall of approximately $306 million ($299,663,573 + 7,104,547). As a result, hospitals in the Miami-Dade region could receive up to approximately $306 million of the $2.3 billion total pool, provided the non-federal share needed to draw down these funds for the region can be provided.

Step 3: Private hospitals work with Miami-Dade County to pass an ordinance establishing the County's intent to assess private hospitals and deposit collected funds into the County LPPF. When necessary, the County provides AHCA an Intergovernmental Transfer ("IGT") from the LPPF to provide a share of the non-federal funds needed to support the DPP in the region.

Step 4: Pursuant to the ordinance, the County passes resolutions when necessary to set the rate for collection of LPPF funds. The process for setting the rate and collecting the LPPF funds is outlined in Steps 5-7, below.

Step 5: The hospitals in Miami-Dade submit a rate recommendation to the County based on a calculation of the IGT need for Region 11.

Rate Setting

The rate will equal the IGT need + 10%.

For example: In order to draw down the $306 million to cover the Medicaid shortfall experienced by Region 11, hospitals in Miami-Dade County must contribute approximately $117 million. The sum due from each hospital is a percent of net patient revenue (or some alternative metric).

Therefore, the calculation would be:

$117 million (Projected IGT need) * 110% (Buffer) / $39.74 billion (Total Gross Patient Revenue) = **0.32%**

The support for the tax base, the Total Gross Patient Revenue for this example, will be provided by the hospitals via the most recent Medicare Cost Report. The Medicare Cost Reports used for this example simulation are attached as "Exhibit B." A detailed table of the analysis for this example showing a breakdown by Miami-Dade private hospital is attached as "Exhibit C."

Once the calculation has been made to determine the rate needed for the LPPF, the County will then approve an LPPF resolution with the recommended rate (in this example, 0.32%).

Step 6: After passing the resolution, Miami-Dade County invoices hospitals using the set rate (in this example, 0.32% of Total Gross Patient Revenue).

Step 7: Hospitals make mandatory payments to Miami-Dade County, which deposits them into the LPPF bank account.

Step 8: Miami-Dade County sends LPPF funds collected (approximately $117 million) to AHCA.

Step 9: After the LPPF funds receive federal match, private hospitals in Miami-Dade County's Medicaid region will receive approximately $306 million directly from the MCOs as rate enhancements, or add-on, for covered services.

It is important to note that the way the hospitals will receive the $306 million is via the MCOs. This is required by federal regulation. This occurs through a rate increase delivered to the MCOs by AHCA. AHCA will provide the MCOs a rate increase to their Managed Medicaid base payments at a rate to pay out approximately $306 million. The rate add-on is illustrated in the table below. Again, this illustration continues using the same example data used above.

Managed Care Regions	Provider Class	$ Allocation of DPP Pool	MCO Payments	DPP Rate Increase by Region by Class
		A	B	C = B / A
11	Public	$ 217,271,643	$ 143,325,253	151.59%
11	Private	$ 299,663,573	$ 528,574,226	56.69%
11	Cancer	$ 7,104,547	$ 36,417,917	19.51%

Based on the 2018 data, each private hospital would receive a rate increase of 56.69% and the cancer hospital(s) would receive a rate increase of 19.51% within Region 11. These rates would pay out the $306 million to the hospitals within the Private and Cancer classes within Region 11.

Jason Durrett

Jason Durrett
Adelanto Health Care Ventures

7/11/2021
Date

Exhibit A – Jason Durrett CV

Jason A. Durrett, MHA, CRCR

4512 Tanglewood Estates Drive ▪ Leander, TX ▪ 78641
Office (512) 814-2441 ▪ Jason@ahcv.com

PROFILE

A combined 17+ years of experience working with health care organizations nationally. Collaborating closely with hospital and health system CEOs and CFOs, to develop and oversee large-scale acquisitions, regulatory, revenue cycle, and managed care initiatives. Consulted on a number of health care-related topics including, Medicaid supplemental payment programs, transaction due diligence, clinical documentation improvement, optimizing reimbursement rates and managed care negotiations. Spoken nationally for HFMA and ACHE about hospital sustainability and rational pricing. Provided consulting services to a wide range of health care organizations, including academic medical centers, ambulatory surgery centers, community hospitals, physician practices and managed care organizations. Strong motivator, ability to manage up and down, with excellent interpersonal and verbal communication skills

EXPERIENCE

Adelanto HealthCare Ventures L.L.C 2017 – Current

Vice President of Finance (Austin, TX)

Responsibilities include leading the development of Medicaid Supplemental Payment Programs in collaboration with locally based partnerships between local governments and healthcare providers (i.e., Local Provider Participation Fund ("LPPF") across the United States while continuing to assist providers with services around boosting revenue, increasing financial efficiency and transaction due diligence.

- Development of tools tailored specifically to assist healthcare providers in understanding projected reimbursement opportunities and monitor cash flow.
- Experience in working with governmental entities to implement and monitor over thirty Local Provider Participation Funds ("LPPFs") in the state of Texas. The process includes building collaboration between providers and their local governmental partners to implement assessment rates, intergovernmental transfers with the state and other responsibilities to ensure appropriate funding is going to support the local safety-net community.
- Subject matter expert as it relates to identifying opportunities for hospital providers to access supplemental payments.
- Advise participating clients concerning regulatory risks and changes, and aid in responding to governmental inquiries related to the state and/or federal supplemental payment programs.
- Performed managed care impact analyses and rate analytics to assist hospitals in their due diligence efforts related to the seller and buyer sides of multiple acquisitions.
- Monitored the implementation and assisted Texas providers in the management of the Uniform Hospital Rate Increase Program ("UHRIP") to assist hospitals in reducing their Medicaid uncovered costs. Over a five-year period, the program has increased from $600 million to a proposed $5.2 billion (largest in the United States) in payments to hospitals.

- Work and development strategic responses with healthcare CEOs to assist in maintaining the funding requirements needed to sustain the safety-net community.

JTaylor 2014 – 2017

Manager of Consulting Services (Fort Worth, TX)

Responsibilities include leading the development of the healthcare advisor practice in Texas, managing and implementing multiple physician and hospital acquisitions and transactions, and development and implementation related revenue cycle planning and management.

- Strong expertise in revenue cycle management for outpatient surgery centers, physician practices, and hospitals in both a private and county hospital setting.
- Proficient in the Microsoft Office suite to manage large datasets received from provider's patient financial service platform (i.e., EPIC, Meditech, Cerner, CPSI, etc.) as well as developing reports.
- Subject matter expert in billing and collection practices. Developed monthly and quarterly reports detailing the organizations current performance to leading organizations within the market and nationally. The implementation of these practices resulted in one organization increasing net revenue by 10% a year.
- Developed and implemented revenue cycle benchmark reporting tool for several community hospitals. Presented monthly reports to Senior Leadership to assist with the reallocation of resources.
- Experienced in developing case, expense and net revenue simulations related to the potential acquisition of the healthcare provider (i.e., physician practice, hospital, health system).
- Negotiation, strategic pricing and successful closure managed care contracts related to the largest otolaryngologist practice in the state resulting in a 30% increase in managed care rates.
- Collaboration with large management company in the acquisition of multiple physician owned hospitals and ambulatory surgery centers with a value between $10 million and $125 million. Validated accuracy and appropriateness of revenue levels and accounts receivable balances presented on entity financial statement through testing of, and comparisons to entity billing data and related reimbursement provisions.
- Performed multiple assessments of physician and hospital billing resulting in the identification of revenue leakage due to inaccurate payments from insurance companies and uncollected bad debt from customers.
- Managed and redirected staff teams for hospital due diligence, managed care contracting and special projects.
- Firm lead related to the first annual JTaylor volunteer day.
- Strategic director related to education and marketing for the healthcare division.

McGladrey 2013 – 2014

Manager of Consulting Services (Fort Worth, TX)

Responsibilities include leadership of the Dallas healthcare division, strategic sales and new business development of ICD-10 and revenue cycle projects, leading the development and implementation of client related services focusing around revenue cycle planning and management, hospital acquisitions, strategic financial plans and priorities, managed care contract reviews and negotiations.

- Creation and implementation of McGladrey's ICD-10 assessment go to market strategy.

- Development of comprehensive ICD-10 implementation strategy that identified the risks and associated mitigation strategies related to the organization. Strong expertise in revenue cycle management for outpatient surgery centers, physician practices, and hospitals in both a private and county hospital setting.
- Managed project team that identified $1.5 million in total revenue impact opportunity related to rational pricing for a small health system by identifying services where the organization can increase pricing to non-transparent services and lowering pricing to enable the hospital to be competitive within the market.
- Responsibility and management of the Dallas business development and marketing healthcare department, individually targeted customer marketing materials and support of the firm's nationwide healthcare development initiatives.
- Selected by the Executive Management Team to speak nationally on the revenue impact related to ICD-10 at Healthcare Financial Management Association's regional conferences

Ernst and Young LLP 2010 – 2013

Senior Consultant (Dallas, TX)

Responsibilities include forecasting, analyzing and developing deliverables for various engagement teams and development efforts, frequent status reporting to Regional and North American advisor teams, ad hoc analyses

- Provide recommendations and corrective actions to service line managers to increase profitability of individual services
- Performed revenue cycle due diligence to identify front office revenue leakage
- Developed comprehensive training plans for various health plans to conduct a best practice application orientation
- Assisted various clients with implementing ICD-10 policies and procedures
- Developed integration scripts for a health plan's quality assurance team to verify the quality of the application

INTEGRIS Health System **2004 – 2009**

Manager of Strategic Operations (Oklahoma City, OK)

Responsibilities include inventory control, forecasting, reporting and analysis.

- Developed annual market reports for each of the 15 INTEGRIS facilities.
- Assisted with the design and construction of INTEGRIS Cancer Institute.
- Devised cost saving techniques focused around various remodel efforts done within the organization.
- Designed a Cardiology Strategic Plan.

EDUCATION

Trinity University, San Antonio TX

- Masters in Health Care Administration (2011)

Oklahoma State University, Stillwater, OK

- Bachelor of Science – Biological Sciences (2007)

Certified Revenue Cycle Representative, HFMA (2016)

ACTIVITIES

- Former President of the Hispanic Wellness Coalition and Chair of the North Texas Wellness Fair
- Education Chair of the American College of Healthcare Executives
- Healthcare representative of the Fort Worth Chamber of Commerce
- Child sponsor for African New Life Ministries

Exhibit B – 2019 Medicare Cost Reports for Miami-Dade Hospitals

ON FILE WITH THE CLERK BECAUSE IT IS OVER 2500 PAGES

Exhibit C – Miami-Dade DPP and LPPF Analysis

Hospital DPP and LPPF Calculation
Year 1

WORKING DRAFT
SUBJECT TO CHANGE

Hospital ID #	Provider Name	Hospital System	City	Gross Patient Revenue	DPP Funding Available for Private Hospitals	Conversion to IGT	LPPF Assessment Rate	LPPF Mandatory Payment	Projected DPP Funding
				A	B	C = B * (1 - FMAP (61.96%))	D = (C*110%) / A	E = D * A	F
10960600	Coral Gables Hosp	Tenet Healthcare	Coral Gables	$ 1,171,551,874				$ 3,783,938	$ 5,418,530
100296	Doctors Hosp	Baptist Health - South Florida	Coral Gables	759,771,466				2,453,949	534,018
11993800	Kindred Hosp - So FL - Coral Gables	Kindred Healthcare	Coral Gables	-				-	1,400,504
10041200	Hialeah Hosp	Tenet Healthcare	Hialeah	1,387,305,597				4,480,791	10,755,607
10053600	Larkin Community Hosp Palm Springs	Larkin Comm. Hosp. System	Hialeah	244,039,962				788,213	2,896,108
10460400	Palmetto General Hosp	Tenet Healthcare	Hialeah	2,602,766,441				8,406,548	16,526,130
104049	Southern Winds Health	Independent	Hialeah	18,321,993				59,177	-
10226100	Homestead Hosp	Baptist Health - South Florida	Homestead	1,068,240,042				3,450,256	14,631,916
12037500	Aventura Hosp And Med Ctr	HCA	Miami	3,039,902,039				9,818,431	9,294,135
10035800	Baptist Hosp of Miami	Baptist Health - South Florida	Miami	5,512,917,724				17,805,904	28,346,629
10270900	Encompass Rehab Hosp of Miami	Encompass Health	Miami	40,545,970				130,957	768,999
12013800	Kendall Regional Med Ctr	HCA	Miami	4,531,726,862				14,636,803	15,479,710
12005700	Larkin Community Hosp	Larkin Comm. Hosp. System	Miami	409,946,219				1,324,065	4,276,518
100277	Miami Jewish Hlth Sys	Independent	Miami	73,857,651				238,549	-
10060900	Nicklaus Children's Hosp	Nicklaus Child	Miami	1,831,828,387				5,916,533	131,653,437
10049800	North Shore Med Ctr	Tenet Healthcare	Miami	3,019,954,034				9,754,002	19,425,074
10058700	South Miami Hosp	Baptist Health - South Florida	Miami	2,059,078,895				6,650,518	13,278,670
102001	SSH - Miami	Select Medical Corporation	Miami	107,617,108				347,587	-
10047100	University of Miami Hosp And Clinics	University of Miami	Miami	7,539,860,575				24,352,627	7,104,547
103036	West Gables Rehab Hosp	Select Medical Corporation	Miami	68,146,257				220,102	-
3226500	West Kendall Baptist Hosp	Baptist Health - South Florida	Miami	1,112,936,357				3,594,619	6,498,932
10170200	Westchester General Hosp	Independent	Miami	177,761,580				574,143	3,013,695
10046300	Mount Sinai Med Ctr	Independent	Miami Beach	2,775,388,037				8,964,090	11,122,993
102031	Promise Hosp of Miami	Select Medical Corporation	Miami Lakes	117,014,168				377,938	-
12002200	St Catherine's Rehab Hosp	Catholic Health Services	North Miami	72,544,779				234,309	1,414,082
Total and %'s				**$ 39,743,024,017**	**$ 306,768,120**	**$ 116,694,593**	**0.32%**	**$ 128,364,052**	**$ 303,840,235**