MEMORANDUM

Agenda Item No. 11(A)(10)

TO: Honorable Chairman Oliver G. Gilbert, III and Members, Board of County Commissioners

DATE: July 2, 2024

FROM: Geri Bonzon-Keenan County Attorney

SUBJECT: Resolution authorizing the imposition of a Mandatory Payment for the Low Income Pool Supplemental Payment Program pursuant to section 18-51 of chapter 18 of the Code against certain real property to fund the non-federal share of Medicaid and Medicaid managed care payments to benefit existing and newly licensed hospital properties; delegating authority to the County Mayor to execute required agreements in connection with the Medicaid Low Income Pool Supplemental Payment Program; and providing for the annual proceedings for imposing the Mandatory Payment

Resolution No. R-629-24

The accompanying resolution was prepared and placed on the agenda at the request of Prime Sponsor Senator René García.

Geri Bonzon-Keenan
County Attorney

GBK/ks

MEMORANDUM
(Revised)

TO: Honorable Chairman Oliver G. Gilbert, III
and Members, Board of County Commissioners

DATE: July 2, 2024

FROM: Geri Bonzon-Keenan
County Attorney

SUBJECT: Agenda Item No. 11(A)(10)

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. 11(A)(10)
7-2-24

RESOLUTION NO. R-629-24

RESOLUTION AUTHORIZING THE IMPOSITION OF A MANDATORY PAYMENT FOR THE LOW INCOME POOL SUPPLEMENTAL PAYMENT PROGRAM PURSUANT TO SECTION 18-51 OF CHAPTER 18 OF THE CODE OF MIAMI-DADE COUNTY, FLORIDA AGAINST CERTAIN REAL PROPERTY TO FUND THE NON-FEDERAL SHARE OF MEDICAID AND MEDICAID MANAGED CARE PAYMENTS TO BENEFIT EXISTING AND NEWLY LICENSED HOSPITAL PROPERTIES; DELEGATING AUTHORITY TO THE COUNTY MAYOR OR COUNTY MAYOR'S DESIGNEE TO EXECUTE REQUIRED AGREEMENTS IN CONNECTION WITH THE MEDICAID LOW INCOME POOL SUPPLEMENTAL PAYMENT PROGRAM; AND PROVIDING FOR THE ANNUAL PROCEEDINGS FOR IMPOSING THE MANDATORY PAYMENT

WHEREAS, this Board created chapter 18, article IV of the Code of Miami-Dade County, Florida ("Code"), authorizing mandatory payments to fund the non-federal share of Medicaid and Medicaid managed care payments to benefit properties upon which private for-profit or not-for-profit licensed hospitals are located that provide hospital services in Miami-Dade County, Florida ("Institutional Health Care Providers"); and

WHEREAS, pursuant to section 18-51 of the Code, the Board, by a duly enacted resolution, may authorize the imposition of a Mandatory Payment for each Medicaid Supplemental Payment Program against those properties on which the Institutional Health Care Providers are situated ("Properties"); and

WHEREAS, section 409.908, Florida Statutes authorizes intergovernmental transfers of funds pursuant to a Low Income Pool Supplemental Payment Program to help offset the unreimbursed cost of Institutional Health Care Providers performing medical services for indigent, uninsured Floridians; and

WHEREAS, pursuant to section 18-50 of the Code, the Low Income Pool Supplemental Payment Program is an authorized Medicaid Supplemental Payment Program within the County; and

WHEREAS, the Medicaid payments proposed for funding from the Mandatory Payments are those which support the Low Income Pool Supplemental Payment Program that results in reimbursement for charity care services; and

WHEREAS, the Properties benefit from the imposition of such Mandatory Payments as described in chapter 18, article IV of the Code, and as set forth in the reports attached hereto as Composite Exhibit A; and

WHEREAS, the Board desires to authorize the imposition of a Mandatory Payment against the Properties for the Low Income Pool Supplemental Payment Program,

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF MIAMI-DADE COUNTY, FLORIDA, that:

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

Section 2. The imposition of the Mandatory Payment against the Properties for the Low Income Pool Supplemental Payment Program is authorized pursuant to section 18-51 of the Code.

Section 3. Pursuant to section 18-52 of the Code, 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 Low Income Pool Supplemental Payment Program, following approval by the County Attorney's Office as to legal sufficiency.

Section 4. Pursuant to section 18-53 of the Code, upon an annual petition requesting the Mandatory Payment, the Board, by a duly enacted resolution, may impose the Mandatory Payment Against the Properties for the purposes provided in this resolution and chapter 18, article IV of the Code.

The Prime Sponsor of the foregoing resolution is Senator René García. It was offered by Commissioner **Sen. René García**, who moved its adoption. The motion was seconded by Commissioner **Raquel A. Regalado** and upon being put to a vote, the vote was as follows:

Oliver G. Gilbert, III, Chairman	**aye**		
Anthony Rodríguez, Vice Chairman	**aye**		
Marleine Bastien	**aye**	Juan Carlos Bermudez	**aye**
Kevin Marino Cabrera	**aye**	Sen. René García	**aye**
Roberto J. Gonzalez	**aye**	Keon Hardemon	**aye**
Danielle Cohen Higgins	**aye**	Eileen Higgins	**absent**
Kionne L. McGhee	**aye**	Raquel A. Regalado	**aye**
Micky Steinberg	**aye**		

The Chairperson thereupon declared this resolution duly passed and adopted this 2nd day of July , 2024. This resolution shall become effective upon the earlier of (1) 10 days after the date of its adoption unless vetoed by the County Mayor, and if vetoed, shall become effective only upon an override by this Board, or (2) approval by the County Mayor of this resolution and the filing of this approval with the Clerk of the Board.

MIAMI-DADE COUNTY, FLORIDA
BY ITS BOARD OF
COUNTY COMMISSIONERS

JUAN FERNANDEZ-BARQUIN, CLERK

By: **Basia Pruna**
Deputy Clerk

Approved by County Attorney as
to form and legal sufficiency.

Jorge Martinez-Esteve
Christopher C. Kokoruda

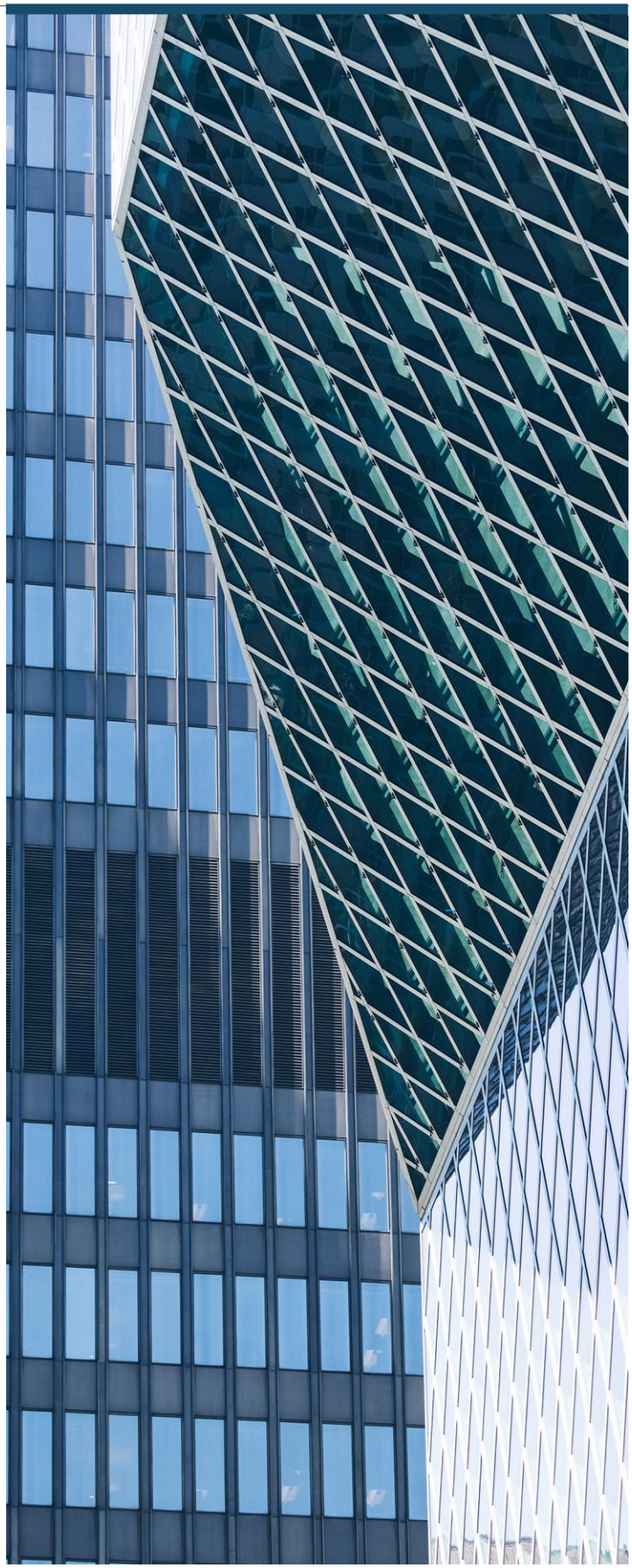
Impact Analysis of Supplemental Payment Programs

Miami-Dade Local Provider Participation Fund

Low Income Pool

Adelanto HealthCare Ventures and Miami-Dade County Board of County Commissioners

June 7, 2024



NEWMARK

June 7, 2024

Re: Miami-Dade Local Provider Participation Fund – Low Income Pool

To whom it may concern,

I currently serves as an Executive Vice President and National Hospitals & Behavioral Healthcare Lead for Newmark Valuation & Advisory's Healthcare & Seniors Housing Specialty Practice. In this role, I oversee a team of experts whose innovative, consulting-driven approach provides best-in-class valuation and consulting services for all Hospital and Behavioral Healthcare facilities.

Additionally, I am involved with the preparation and review of appraisal reports on a broad range of healthcare-oriented properties including short term acute care hospitals, critical access hospitals, long-term acute care hospitals, inpatient rehabilitation facilities, rural emergency hospitals, veterans hospitals, micro-hospitals, freestanding emergency departments and specialty hospitals, as well as institutional and residential type behavioral healthcare facilities.

I have completed many different types of valuations, including proposed, partially completed, renovated and existing structures, as well as various consulting services such as market rent studies, going concern valuations, highest and best use analyses for national healthcare providers, feasibility studies, bed-need studies, and specialty USDA lending for rural hospitals. I also have significant experience in litigation assignments, including the preparation of appraisals and providing expert witness testimony for federal bankruptcy proceedings. I earned the MAI designation from the Appraisal Institute and have completed continuing education courses and seminars sponsored by the Appraisal Institute and other real estate factions on an annual basis to maintain state licensing requirements.

The intended use of this report is solely to evaluate the impact of supplemental payment programs on hospital property values for those assessed providers that pay a mandatory payment into the Miami-Dade County Local Provider Participation Fund. The LPPF funds are then used to draw down matching federal funds under such programs to reduce the Medicaid reimbursement shortfall, reimburse hospitals for medical professional training, and/or offset costs of charity care provided to the indigent, uninsured population of the county.

Sincerely,

Timothy P. Gillespie, MAI

Timothy P. Gillespie, MAI
Executive Vice President
4221 W Boy Scout Blvd, Ste 440
Tampa, FL 33607
t 813-262-8181
nmrk.com

NEWMARK

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Executive Summary

2024 Miami-Dade Local Provider Participation Fund

Since 2021, Miami-Dade's nonpublic hospitals have paid an annual special assessment to the county. The hospital special assessment payments unlock federal matching dollars. The dollars help narrow the reimbursement gap the county's hospitals face when providing Medicaid services.

Although the assessment has addressed only this one area of hospital need for three years, the assessment has potential to provide a greater benefit. The assessment can unlock dollars to assist not only in Medicaid reimbursement, but also in education and offsetting costs of charity care. In 2024, Miami-Dade's hospitals wish to build on the success of the special assessment to unlock federal dollars in other areas of need.

DIRECTED PAYMENT PROGRAM

- Miami-Dade County created its hospital assessment program to fund the hospital directed payment program, which was implemented by the state in 2021.
- The hospital directed payment program (DPP) narrows the Medicaid reimbursement gap.
  - Until Florida created its DPP, hospitals received roughly 60 cents on the dollar in Medicaid reimbursement.
  - The DPP helps hospitals get closer to 80 cents on the dollar.
- Florida funds its share of the DPP through special assessments levied by local governments on the nonpublic hospitals in their jurisdictions. The dollars draw down federal match, and the resultant pool of funds narrows the reimbursement gap.
- This model has successfully brought federal tax dollars paid by Floridians back to the state to fund safety net care.

2024 OPPORTUNITY

- Miami-Dade County can unlock dollars for programs beyond DPP for its hospitals by levying a special assessment capable of meeting the need.
- To do so, Miami-Dade must eliminate any DPP-specific restrictions in its existing hospital-assessment ordinance.

IMPLEMENTATION

- The assessment process will remain the same: all hospitals will pay the assessment, and they will receive some subsidy based on their respective shares of underfunded care provided.
- After or concurrent with the county's ordinance modification—and before the close of the 2023-2024 county fiscal year—Miami-Dade's Board must adopt a rate capable of generating funds to support DPP, LIP, and IME.
  - Only one rate is required to support the various Medicaid supplemental programs, and each provider receives only one invoice.
- The County must execute 3 Letters of Agreement (LOA) by the statutory deadline of October 1, 2024: one for DPP, one for LIP, and one for IME.
- When the Agency for Health Care Administration calls for funds for each program, the County must make the transfer.
- As with DPP, the state handles all disbursements to Miami-Dade County hospitals. The DPP, LIP, and IME payments will reach local hospitals in 2025.

SUMMARY

With a change specifying that the special assessment can support "the hospital directed payment program, the low income pool program, the indirect medical education program, and any similar supplemental payment programs that are specifically designed to support underfunded hospitals that treat indigent patients," Miami-Dade's hospital assessment can support DPP, LIP, IME, as well as any future need, in all future years.

Low Income Pool

- In addition to providing Medicaid care, Florida's hospitals annually devote over $3 billion in services for indigent, uninsured Floridians.
    - These "charity care" cases do not qualify for Medicaid, but the patients cannot pay hospitals for the costs of care.
- The Low Income Pool (LIP), authorized in the annual General Appropriations Act and further explained in § 409.908, Fla. Stat, helps offset the cost of performing services for this population.
- Although the federal government has committed resources to offset these costs each year, Florida's hospitals have been unable to access approximately one third of the available federal funds. The hospitals have been unable to identify state dollars to drawn down the available federal funds.
- Using the assessment to fund LIP will allow Miami-Dade hospitals to access dollars otherwise left on the table.

I have been provided a report titled "Rate Setting and Operation of the Low Income Pool Program for Private Hospitals in Miami-Dade County" which was prepared by David Elliott – Vice President of Finance with Adelanto HealthCare Ventures which provides a more detailed overview of the program steps and the rate setting Process. Mr. Elliott explains the program steps as follows:

> ***"Step 1:*** *AHCA set the LIP program pool size in the Florida section 1115 waiver at just over $2.1 billion per year through 2030. To allocate these funds, AHCA assigns Florida hospitals to one of five different LIP program tiers, each tier with its own qualifications. AHCA distributes funding within each tier based on charity care costs identified in each hospital's Schedule S-10 from the Medicare Cost Report ending on or before June 30, 2023.*
>
> *The increased payments will be determined individually for each of Florida's 5 Tiers defined for the LIP program.*
>
> ***Step 2:*** *To group the hospitals into their appropriate tier, AHCA utilized the 2022 FHURS reports to identify the reported costs written off to charity care for each facility, then compared the written-off charity costs to the costs incurred from treating patients with commercial insurance. The type of hospital and ratio of charity-to-commercial costs determine which hospitals fall into which tier within the LIP program. As an example, State Fiscal Year (FY2025) tier 1 of the LIP program will be for private hospitals only with a charity-to-commercial cost ratio of greater than 4.55%, while tier 5 is for private hospitals only with a charity-to-commercial cost ratio of less than 4.55%. Note that AHCA determines the qualifying criteria for the tiers, and the criteria are subject to change.*
>
> *The local hospitals in Miami-Dade County are grouped into several different tiers of the LIP model, based on their hospital type (private vs public) and their charity-to-commercial cost ratios. The current modelling shows that Miami-Dade County has facilities in tiers 1, 2, 3 and 4 which would require funding of the non-federal share for the LIP program.*
>
> *The table below shows how the funds will be allocated for each hospital tier, assuming that the $2.1 billion total statewide pool is able to be fully funded for FY2025:*

LIP Groups / Tiers	Total Cost of Charity Care	% Allocation of LIP Pool	$ Allocation of LIP Pool
Group 1 (Hospitals)			
Tier 1	869,467,786	34.55%	747,742,295
Tier 2	664,901,888	30.73%	664,901,888
Tier 3	335,958,731	15.52%	335,958,731
Tier 4	256,780,319	10.20%	220,831,074
Tier 5	520,309,084	0.24%	5,203,091
Group 2 (Med School Physicians)	100,536,805	4.65%	100,536,805
Group 3 (FQHCs/RHCs)	54,903,104	2.54%	54,903,104
Group 4 (Behavioral Health Providers)	33,948,462	1.57%	33,946,555
State Totals	**$ 2,836,806,179**	**100.00%**	**$ 2,164,023,544**

Using the most recent Medicare Cost Report data available, I project Florida hospitals will be eligible to receive reimbursement for eligible charity care costs in the amount of approximately $2.1 billion. This sum funds all tiers of the LIP program, and it represents an increase over the historical amount of $1.4 billion paid out for FY2024. The lower amount in FY2024 resulted from the fact that the majority of Florida hospitals were unable to identify a source of funding for the non-federal share.

Step 3: *Private hospitals work with Miami-Dade County to pass an amended ordinance establishing the County's intent to assess private hospitals and deposit the collected funds into the County Local Provider Participation Fund ("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 approved programs, including LIP.*

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 nonpublic hospitals in Miami-Dade County submit a rate recommendation to the County based on a calculation of the IGT need for their share of each tier. The assessment rate and collection of LPPF funds will be sufficient to fund the non-federal share of all supplemental payment programs funded through the LPPF, not just the LIP program.*

The amount of the assessment required of each hospital may not exceed an amount that, when added to the amount of other required assessments, if any, exceeds the percentage in 42 C.F.R. § 433.68(f)(3)(i)(A) with respect to the total aggregate net patient revenue for all hospitals in Florida. The current percentage is six percent. Note that because this percentage is a statewide percentage and because assessments may exclude certain revenues, assessments imposed at the local level may exceed six percent. The Miami-Dade County assessment will generate sufficient revenue to fund the non-federal share of supplemental payment programs to be funded through the LPPF, while remaining under the limit in federal law.

Rate Setting

As an example, in order to draw down the $2.1 billion to reimburse charity care costs incurred by Florida hospitals,

hospitals in Miami-Dade County must contribute approximately $148 million. This would be combined with the amounts required from the Miami-Dade private hospitals to fund the DPP, FCHP, and IME programs as well, for a grand total of $426 million being projected for the total IGT need. It is estimated that the LPPF has an existing account balance of $5 million, which means that an assessment of $421 million ($426M - $5M) would be required to fully fund this amount. The sum due from each hospital is a percent of net inpatient and outpatient patient revenue (or some alternative metric).

Therefore, the inpatient and outpatient assessments would be computed as follows (noting that the sums below are estimates, subject to change, and for illustrative purposes only):

*$421M (Projected need) * 54% (inpatient portion) / $4.02B (Inpatient Net Patient Revenue excl. MCR) = 5.69%*

*$421M (Projected need) * 46% (outpatient portion) / $4.56B (Outpatient Net Patient Revenue excl. MCR) = 4.22%*

The support for the assessments—inpatient and outpatient net patient revenues excluding Medicare revenues in this example—will be provided by the hospitals via the most recent Medicare Cost Reports. The Medicare Cost Reports used for this example will be attached to the rate assessment resolution. A table showing a breakdown by each Miami-Dade private hospital will be attached to the same resolution.

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, 5.69% for inpatient and 4.22% for outpatient).

***Step 6:** After passing the resolution, Miami-Dade County invoices hospitals using the set rate (in this example, 5.69% for inpatient and 4.22% for outpatient net patient revenues excluding Medicare). Each hospital will receive an invoice for the assessment in an amount sufficient to fund the non-federal share of all supplemental payment programs that are funded using the LPPF.*

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

***Step 8:** Miami-Dade County sends LPPF funds collected (approximately $148M) to AHCA. Any additional payment for any other supplemental payment programs funded using the LPPF will be sent to AHCA when the agency issues a call for the funds.*

***Step 9:** After AHCA receives the federal match, private hospitals in each tier will receive approximately $1.85 billion directly from AHCA, assuming all other required non-federal share funds are collected from the other participating governmental entities in Florida. Such benefit will be specified for each payor and will be fairly and reasonably apportioned according to eligible services rendered.*

It is important to note that the hospitals will receive the $1.85 billion directly from AHCA. This is different from the disbursement process in DPP, which comes from the managed care organizations in a directed payment model."

Market Participation Discussion

John P. Nero - Newmark

John Nero serves as Senior Managing Director of Newmark's Healthcare Capital Markets Group. Based in Newmark's New York headquarters, Mr. Nero works on a variety of healthcare real estate engagements, including real estate portfolio monetization's, asset sales and financings, debt and equity placements and development advisory on behalf of healthcare provider and institutional investor clients. As part of his role, Mr. Nero leads the debt capital markets initiative for the healthcare capital markets practice, specializing in acquisition, construction and refinancing facilities for borrowers in the healthcare sector.

John has worked with a wide range of client types, including healthcare systems, hospitals, REITs, and private real estate investment and development firms. His experience with healthcare real estate spans a broad range of asset classes, including medical office buildings, seniors housing and post-acute care facilities, among others.

After discussing the Miami-Dade Local Provider Participation Fund with Mr. Nero, he indicated that a hospital's participation in the LPPF supports an increase in real estate value occupied by that provider, were the participation to result in an increase in NPSR (Net Patient Service Revenue) and EBITDAR (Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent). The value increase would be driven by a higher EBITDAR-to-rent coverage level (Lease Coverage Ratio) a key metric investors use to determine the profitability/strength of the operator for high-acuity real estate. All other factors the same, a higher Lease Coverage Ratio would likely translate to a lower capitalization rate selection for the real estate, which would result in a higher real estate value conclusion.

Brian Haapala, MHSA, FACHE – Stroudwater Capital Partners

Brian Haapala is the Chief Executive Officer of Stroudwater Capital Partners and has served as a trusted advisor to health executives and Boards of Directors for over two decades with a focus on developing sustainable healthcare systems, from operational and financial improvement to capital investment. Prior to joining Stroudwater Capital Partners, Brian was Senior Vice President and Chief USDA Underwriter for Colliers Mortgage where he was accountable for evaluating and approving all loan commitments as the largest healthcare lender in the USDA Community Facilities program. Over his career, Brian has led hundreds of client projects in strategic facilities master planning, strategic planning, turnarounds, and affiliation engagements for clients in every region of the country. Brian has planned and/or financed over $1 Billion in facility projects including hospital and ambulatory care center replacements, renovations and expansions for systems and community hospitals up to 600 beds. He started working with the USDA program leadership over 15 years ago as an expert resource and trainer in healthcare operations.

Brian is passionate about securing capital investments to modernize the aging rural healthcare infrastructure and increase high-quality, high-value services for rural people and places. To fulfill this ambitious vision, Brian connects financing plans with clients' strategy, operations, and financial success factors for the future. He is board-certified in Healthcare Management as a Fellow with the American College of Healthcare Executives and is a licensed Financial Advisor and Municipal Securities Representative.

Mr. Haapala indicated that a hospital operator's participation in programs that unlock federal matching dollars to help narrow the Medicaid reimbursement gaps/underpayment can provide a path to higher profitability levels to those facilities which are most in need of support. These 'tax and match' programs are particularly vital to hospitals in rural locations and/or hospitals whose patient base is more heavily funded through Medicaid reimbursement. In Mr. Haapala's experience, state and hospital participation in these programs has resulted in lower closure rates of at-risk health systems. This lower risk of closure can be further reflected by a positive effect on the value of the underlying real estate attributable to lower capitalization rate selection, selection of comparables with higher profitability levels, and overall reconciliation/weight to account for lower risk of operator default.

Impact on Valuation

Hospital Going Concern Valuation Methodology

Many acquirers, and the analysts who follow them, consider the price/EBITDA ratio to be an important measure for valuing an acquisition. In the hospital acquisition market, because of the lack of timely disclosure of financial data, mostly Medicare cost reports, and the disinclination of buyers to reveal current EBITDA of their target hospitals, the analysis is often based on somewhat old data. For example, for many deals in 2024, the EBITDA figures are from the 2022-2023 reporting year for the target hospital, unless the seller/buyer disclosed more recent data.

As such, it has always been difficult to derive an accurate price/EBITDA multiple in the hospital acquisition market because the financial data tends to be old. It matters less for the price/revenue because the level of revenues does not fluctuate as much year-to-year as does the operating expenses and subsequent level of cash flow. Because the operator /buyer has more current financial data when making the offer, we have to assume that the price/EBITDA multiples in the report are somewhat skewed as they are based on one- to two-year old information. In addition, buyers usually price their acquisitions based on pro forma EBITDA, ignoring the historical performance if they believe it to be misleading.

Even though many statistics in the hospital acquisition market have had wide variances from year to year, the price to revenue multiple has been the most consistent for many years. Although not used as much as the price/EBITDA multiple, the price/revenue multiple is a very reasonable initial benchmark to consider when looking at hospital valuations.

As Price/EBITDA and Price/Revenue are key metrics in tracking/pricing hospitals for transactions, the methodology can additionally be utilized in the valuation of a hospital property using current Revenue/EBITDA and applying a multiplier based on those derived metrics from the market transactions.

In the case of those properties that participate in the Hospital Directed Payment Program, the matching of federal funds could result in an increase to both the Net Patient Service Revenue (NPSR) and the Earnings Before Interest, Taxes, Depreciation, Amortization, and Rent (EBITDAR). Based on the methodology described above, an increase in NPSR and EBITDAR would result in an increase overall value for the Hospital Operations as a Going Concern.

Hospital Real Estate Valuation Methodology

When we appraise a hospital, the valuation is typically based on the going concern and assumes a sale, which includes the transfer of a valid operating license, an assembled workforce, and the transfer of all business assets necessary for the operation of a licensed health care facility and typically transferred with the sale of the property. However, the business assets specifically exclude items that do not typically transfer such as holdings or investments, working capital, accounts receivable, and accounts payable, that are distinctly separate from the real estate.

We typically appraise a hospital as a going concern entity as its real and personal property are supportive of, and tied to, an ongoing business operation. Our market value conclusions are inclusive of real property, business personal property (FF&E), and intangible items (i.e. license, certificate of need, assembled workforce, goodwill, etc.) that are a byproduct of operations of the property as a going concern business entity. Furthermore, these allocations are not reflective of the value of each component on a standalone basis. The exclusion of any one of the components from the going concern would render these individual allocations invalid.

Although the relationship between the going concern and the real estate valuations are separate and distinct from one another, there is a relationship between them that influences decision making for both components. For example, although a particular hospital operation may be profitable with positive business cash flows, if the underlying real estate/physical plant is failing, there may be a

negative effect on the valuation of the going concern to account for the additional risk factor as compared to the comparable going concern transactions. As a secondary example to explore the inverse relationship, a significantly profitable hospital operation may have a positive effect on the valuation of the real estate as the going concern and corresponding cash flows prove a lower risk of tenancy default and a higher likelihood of the real estate occupant's ability to pay for any deferred maintenance/physical needs or improvements.

Given the demonstration above, it is conceivable that an increase in Revenue/EBITDAR attributable to a hospital's participation in the Hospital Directed Payment Program and corresponding increase in Going Concern value, would likely result in an increase in value to the underlying real estate. The value increase would likely be realized in the real estate capitalization rate selection within the income approach, sales comparison approach comparable property/transaction selection or price per square foot reconciliation, and in the overall reconciliation between approaches for the real estate valuation.

Although I do not personally utilize a Lease Coverage Ratio analysis in my valuations due to relatively inconsistent data and wide variances from comparable transactions, investors and market participants including REITs have utilized this analysis in their underwriting and internal valuations. For example, Medical Properties Trust, Inc. is a self-advised real estate investment trust formed in 2003 to acquire and develop net-leased hospital facilities. From its inception in Birmingham, Alabama, the Company has grown to become one of the world's largest owners of hospital real estate. MPT utilizing a Lease Coverage Ratio to track its portfolio/operator's health and for internal valuation/financial reporting.

As mentioned above and within the market participant overviews, the Lease Coverage Ratio method would indicate that an increase in the Going Concern/Operator's Revenue/EBITDAR would result in an increase in value to the underlying real estate position.

Conclusion

After analyzing the information provided by Adelanto HealthCare Ventures, researching the Low Income Pool Program, speaking with multiple market participants and investors, and running through my own internal appraisal analyses, I have concluded that, all else equal, a hospital's location in a county levying special assessments to support hospital supplemental payment programs such as the Low Income Pool Program would result in an increase in underlying real estate value directly attributable to the participation in the program.

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NEWMARK

MDC018

REPORT OF DAVID ELLIOT

Rate Setting and Operation of the Low Income Pool Program for Private Hospitals in Miami-Dade County

Executive Summary: Pursuant to Section 18-51 of Chapter 18 of the Miami-Dade County Code of Ordinances, the hospital mandatory payments may fund any supplemental payment program authorized by the Board of County Commissioners. Among the possible supplemental payment programs is the Low Income Pool (LIP) Program. If Miami-Dade County collects a mandatory payment to fund LIP, the resultant benefit will be fairly and reasonably apportioned according to eligible services rendered.

I. Qualifications

My name is David Elliot. 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 Vice President of Finance at Adelanto HealthCare Ventures ("AHCV"). I have served in this role for over six years. I have over 15 years of experience working in health care finance, including extensive experience with Medicaid supplemental payment programs and local hospital assessments. 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 Low Income Pool ("LIP") program. Through the LIP program, the federal government allows Florida to implement a hospital payment program through the Florida Agency for Health Care Administration ("AHCA") to make LIP payments directly to hospitals to offset charity care costs. These charity care patients do not qualify for Medicaid, nor do they have other forms of insurance. Each hospital writes off the charges associated with these patient visits in accordance with that particular hospital's charity care policy. The hospital makes no attempt to collect the costs incurred from the charity care patient visits.

The federal government has committed resources to offset charity care costs through 2030. In Florida, hospitals that provide charity care may access these federal funds through the Florida LIP program. However, hospitals have been unable to access approximately one-third of the allocated federal funding due to a lack of a required funding source that uses State dollars to draw down the available federal funds.

This Report explains the private hospital LIP program and how the assessment rate-setting process would work for Miami-Dade County. This Report and the data herein are provided for illustrative purposes only.

III. Data

To demonstrate how the rates are set to support the funding need for the LIP program, I used source data gathered from publicly available 2022 Florida Hospital Uniform Reporting System ("FHURS") reports, and the most recently filed Medicare Cost Reports for fiscal years ending on or before June 30, 2023. To determine the funding need for the LIP program, I used the methodology set forth by AHCA in its Reimbursement and Methodology Document.

IV. Program Steps and Rate-Setting Process

Step 1: AHCA set the LIP program pool size in the Florida section 1115 waiver at just over $2.1 billion per year through 2030. To allocate these funds, AHCA assigns Florida hospitals to one of five different LIP program tiers, each tier with its own qualifications. AHCA distributes funding within each tier based on charity care costs identified in each hospital's Schedule S-10 from the Medicare Cost Report ending on or before June 30, 2023.
The increased payments will be determined individually for each of Florida's 5 Tiers defined for the LIP program.

Step 2: To group the hospitals into their appropriate tier, AHCA utilized the 2022 FHURS reports to identify the reported costs written off to charity care for each facility, then compared the written-off charity costs to the costs incurred from treating patients with commercial insurance. The type of hospital and ratio of charity-to-commercial costs determine which hospitals fall into which tier within the LIP program. As an example, State Fiscal Year (FY2025) tier 1 of the LIP program will be for private hospitals only with a charity-to-commercial cost ratio of greater than 4.55%, while tier 5 is for private hospitals only with a charity-to-commercial cost ratio of less than 4.55%. Note that AHCA determines the qualifying criteria for the tiers, and the criteria are subject to change.

The local hospitals in Miami-Dade County are grouped into several different tiers of the LIP model, based on their hospital type (private vs public) and their charity-to-commercial cost ratios. The current modelling shows that Miami-Dade County has facilities in tiers 1, 2, 3 and 4 which would require funding of the non-federal share for the LIP program.

The table below shows how the funds will be allocated for each hospital tier, assuming that the $2.1 billion total statewide pool is able to be fully funded for FY2025:

LIP Groups / Tiers	Total Cost of Charity Care	% Allocation of LIP Pool	$ Allocation of LIP Pool
Group 1 (Hospitals)			
Tier 1	869,467,786	34.55%	747,742,295
Tier 2	664,901,888	30.73%	664,901,888
Tier 3	335,958,731	15.52%	335,958,731
Tier 4	256,780,319	10.20%	220,831,074
Tier 5	520,309,084	0.24%	5,203,091
Group 2 (Med School Physicians)	100,536,805	4.65%	100,536,805
Group 3 (FQHCs/RHCs)	54,903,104	2.54%	54,903,104
Group 4 (Behavioral Health Providers)	33,948,462	1.57%	33,946,555
State Totals	**$ 2,836,806,179**	**100.00%**	**$ 2,164,023,544**

Using the most recent Medicare Cost Report data available, I project Florida hospitals will be eligible to receive reimbursement for eligible charity care costs in the amount of approximately $2.1 billion. This sum funds all tiers of the LIP program, and it represents an increase over the historical amount of $1.4 billion paid out for FY2024. The lower amount in FY2024 resulted from the fact that the majority of Florida hospitals were unable to identify a source of funding for the non-federal share.

Step 3: Private hospitals work with Miami-Dade County to pass an amended ordinance establishing the County's intent to assess private hospitals and deposit the collected funds into the County Local Provider Participation Fund ("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 approved programs, including LIP.

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 nonpublic hospitals in Miami-Dade County submit a rate recommendation to the County based on a calculation of the IGT need for their share of each tier. The assessment rate and collection of LPPF funds will be sufficient to fund the non-federal share of all supplemental payment programs funded through the LPPF, not just the LIP program.

The amount of the assessment required of each hospital may not exceed an amount that, when added to the amount of other required assessments, if any, exceeds the percentage in 42 C.F.R. § 433.68(f)(3)(i)(A) with respect to the total aggregate net patient revenue for all hospitals in Florida. The current percentage is six percent. Note that because this percentage is a statewide percentage and because assessments may exclude certain revenues, assessments imposed at the local level may exceed six percent. The Miami-Dade County assessment will generate sufficient revenue to fund the non-federal share of supplemental payment programs to be funded through the LPPF, while remaining under the limit in federal law.

Rate Setting

As an example, in order to draw down the $2.1 billion to reimburse charity care costs incurred by Florida hospitals, hospitals in Miami-Dade County must contribute approximately $148 million. This would be combined with the amounts required from the Miami-Dade private hospitals to fund the DPP, FCHP, and IME programs as well, for a grand total of $426 million being projected for the total IGT need. It is estimated that the LPPF has an existing account balance of $5 million, which means that an assessment of $421 million ($426M - $5M) would be required to fully fund this amount. The sum due from each hospital is a percent of net inpatient and outpatient patient revenue (or some alternative metric).

Therefore, the inpatient and outpatient assessments would be computed as follows (noting that the sums below are estimates, subject to change, and for illustrative purposes only):

$421M (Projected need) * 54% (inpatient portion) / $4.02B (Inpatient Net Patient Revenue excl. MCR) = **5.69%**

$421M (Projected need) * 46% (outpatient portion) / $4.56B (Outpatient Net Patient Revenue excl. MCR) = **4.22%**

The support for the assessments—inpatient and outpatient net patient revenues excluding Medicare revenues in this example—will be provided by the hospitals via the most recent Medicare Cost Reports. The Medicare Cost Reports used for this example will be attached to the rate assessment resolution. A table showing a breakdown by each Miami-Dade private hospital will be attached to the same resolution.

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, 5.69% for inpatient and 4.22% for outpatient).

Step 6: After passing the resolution, Miami-Dade County invoices hospitals using the set rate (in this example, 5.69% for inpatient and 4.22% for outpatient net patient revenues excluding Medicare). Each hospital will receive an invoice for the assessment in an amount sufficient to fund the non-federal share of all supplemental payment programs that are funded using the LPPF.

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

Step 8: Miami-Dade County sends LPPF funds collected (approximately $148M) to AHCA. Any additional payment for any other supplemental payment programs funded using the LPPF will be sent to AHCA when the agency issues a call for the funds.

Step 9: After AHCA receives the federal match, private hospitals in each tier will receive approximately $1.85 billion directly from AHCA, assuming all other required non-federal share funds are collected from the other participating governmental entities in Florida. Such benefit will be specified and will be fairly and reasonably apportioned according to eligible services rendered.

It is important to note that the hospitals will receive the $1.85 billion directly from AHCA. This is different from the disbursement process in DPP, which comes from the managed care organizations in a directed payment model.

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Date