West Volusia Hospital Authority
WVHA BOARD OF COMMISSIONERS REGULAR MEETING
November 14, 2019, 5:00 p.m.
DeLand City Hall
120 S. Florida Avenue, DeLand, FL
AGENDA

1. Call to Order
2. Opening Observance followed by a moment of silence
3. Approval of Proposed Agenda
4. Consent Agenda
    A. Approval of Minutes October 17, 2019 Special Meeting
    B. Approval of Minutes October 17, 2019 Regular Meeting

5. Citizens Comments
6. Reporting Agenda
    A. UMR October Report – Written Submission
    B. FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a/ Family Health Source (FHS) October Report
        1. Quarterly Prescription Audit, July, August, September 2019
    C. the House Next Door (THND) October HealthCard Report
7. Advent Health Quarterly Report
    A. Advent Health Fish Memorial – Rob Deininger, President and/or Eric Ostarly, CFO
    B. Advent Health DeLand – Lorenzo Brown, CEO and/or Kyle Glass, CFO
8. Discussion Items
    A. EBMS/Veracity Administrative Services Agreement
    B. NEFHS Site Visit Write Up 2019 (attached)
    C. Tentatively Scheduled Meetings 2020
    D. Check Signing Schedule Bi-Monthly Accounts Payable 2020
    E. Fourteenth Addendum – Primary Care Physicians Indigent Hospital Patient
    F. A Proposed Bill with Florida State Legislation to Eliminate the West Volusia Hospital Authority
    G. Follow Up Items
9. Finance Report
    A. October Financials

10. Legal Update

11. Commissioner Comments

12. Adjournment

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS SPECIAL MEETING

DeLand City Hall
120 S. Florida Avenue, DeLand, FL
October 17, 2019
DeLand, Florida
4:00 p.m.

Those in Attendance:
Commissioner Dolores Guzman
Commissioner Andy Ferrari
Commissioner John Hill
Commissioner Voloria Manning
Commissioner Judy Craig

CAC Present:
Elmer Holt
Donna Pepin
Ann Flowers
Jacquie Lewis

Others Present:
Attorney for the Authority: Theodore Small, Law Office of Theodore W. Small, P.A.
Accountant for the Authority: Ron Cantlay, Dreggors, Rigsby & Teal (DRT)
Administrative Support: Eileen Long, DRT

Call to Order

Vice-Chair Guzman established that there was a quorum with four Commissioners present and that Chair Craig was going to arrive late to the meeting.

Vice-Chair Guzman called the meeting to order. The meeting took place at DeLand City Hall in the Commission Chamber, located at 120 S. Florida Ave., DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County, commencing at 4:00 p.m.

Approval of Proposed Agenda

Motion 095 – 2019 Commissioner Ferrari motioned to approve the agenda presented. Commissioner Hill seconded the motion. The motion carried by a 4-0-1 vote.

Citizens Comments

There were none.

Discussion Items

Budget and Healthcare Financing Matters
Veracity/EBMS Proposal

Attorney Small summarized the history of the contractual relationship with the WVHA and Advent Health Systems over the last 20 years and suggested that the Board discuss how they would like to proceed with any future funding for any hospitals after the contract with the WVHA and Advent Health Systems ends on September 30, 2020.

Chair Judy Craig arrived at the meeting at 4:10 p.m. and requested that Vice-Chair Guzman continue to Chair the Special Meeting.

There was Commissioner discussion some believing that it wouldn't be right to fund Halifax Hospital on the West side of the County since Halifax had all but eliminated services to the indigent population on the East side of the County. But there was another train of thought that if the WVHA funded Advent Health Systems they couldn't exclude funding for Halifax.

Commissioner Craig recalled a meeting that she and Attorney Small had with the Advent Health Systems hospital representatives and those same representatives asked the WVHA what it was that the WVHA wanted from the hospitals rather than submitting a proposal for the Board to consider.

There was further Commissioner discussion and consent that if the WVHA were to continue forward with funding Advent Health Systems or any other hospital, they would like this to go through the regular annual application cycle. Further, the Board consented that any future hospital funding would be reimbursed at lesser rates than the current 105% and 125% percent of the Medicare fee schedule.

Vice Chair Guzman asked the Board if they wanted to discuss the Veracity/EBMS proposal at this time?

There was Board consent that they would discuss the Veracity/EBMS proposal during the Regular Meeting.

Commissioner Comments

There being no further business to come before the Board, the meeting was adjourned.

Adjournment

Dolores Guzman, Vice-Chair

WEST VOLUSIA HOSPITAL AUTHORITY
WVHA BOARD OF COMMISSIONERS REGULAR MEETING

DeLand City Hall
120 S. Florida Avenue, DeLand, FL
October 17, 2019
DeLand, Florida
Commencing upon the conclusion of the Special Meeting

Those in Attendance:
Commissioner Dolores Guzman
Commissioner Andy Ferrari
Commissioner John Hill
Commissioner Voloria Manning
Commissioner Judy Craig

CAC Present:
Elmer Holt
Donna Pepin
Ann Flowers
Jacquie Lewis

Others Present:
Attorney for the Authority: Theodore Small, Law Office of Theodore W. Small, P.A.
Accountant for the Authority: Ron Cantlay, Dreggors, Rigsby & Teal (DRT)
Administrative Support: Eileen Long, DRT

Call to Order

Chair Craig called the meeting to order. The meeting took place at DeLand City Hall in the Commission Chamber, located at 120 S. Florida Ave., DeLand, Florida, having been legally noticed in the Daytona Beach News-Journal, a newspaper of general circulation in Volusia County, commencing upon the conclusion of the Special Meeting. The meeting was opened with The Pledge of Allegiance followed by a moment of silence.

Approval of Proposed Agenda

Motion 096 – 2019 Commissioner Hill motioned to approve the agenda as presented. Commissioner Guzman seconded the motion. The motion passed unanimously.

Consent Agenda

Approval of Final Budget Hearing September 26, 2019
Approval of Minutes Regular Meeting September 26, 2019

Motion 097 – 2019 Commissioner Ferrari motioned to approve the Consent Agenda. Commissioner Manning seconded the motion. The motion passed unanimously.

Citizens Comments

There was one.

Reporting Agenda

UMR September Report – Written Submission
FQHC Report, Laurie Asbury, CEO, Northeast Florida Health Services, Inc. d/b/a/ Family Health Source (FHS) September Report
The House Next Door (THND) September HealthCard Report

Discussion Items

Funding Agreements 2019-2020

1. Community Legal Services, Inc. Medical-Legal Partnership program.
2. Healthy Communities – Kidcare Outreach
3. Hispanic Health Initiatives, Inc. Taking Care of My Health
4. Northeast Florida Health Services, d/b/a Family Health Source (FHS) – Consolidated Clinics
5. Northeast Florida Health Services, d/b/a Family Health Source (FHS) — Pharmacy
6. Northeast Florida Health Services, d/b/a Family Health Source (FHS)—Prenatal
7. Rising Against All Odds, Inc.- HIV/AIDS Outreach and Case Management
8. Rising Against All Odds, Inc.— HealthCard Enrollment & Retention Services
9. SMA Healthcare – Baker Act Match
10. SMA Healthcare – Homeless Program
11. SMA Healthcare — Level II Residential Treatment
12. The Healthy Start - Access to Healthcare Services WIS/NOS
13. The Healthy Start – Family Services Coordinator
14. The House Next Door – Mental Health Services
15. The House Next Door — Eligibility Determination Services
16. The Neighborhood Center of West Volusia "Access to Care"
17. The Neighborhood Center of West Volusia "Health Care Navigation"
18. Volusia County Health Department — Florida Department of Health (Dental Care)
19. Fourteenth Addendum — Primary Care Physicians Indigent Hospital Patient

Motion 098 – 2019 Commissioner Guzman motioned to approve funding agreements 1 through 19, pulling 4 and 6 for further discussion. Commissioner Manning seconded the motion.

Commissioner Ferrari requested a friendly amendment to pull 19 for further discussion. Commissioner Ferrari's friendly amendment was accepted.

The motion passed unanimously.

Commissioner Hill expressed his concern over the variance in the NEFHS Medicaid rate of reimbursement as a Federally Qualified Health Center (FQHC) enhanced at $123.58 versus what a regular primary care physician would be reimbursed that would be far less than that amount. Commissioner Hill wanted to know what NEFHS' lowest rate of reimbursement was from any of their other payer sources.

Ms. Laurie Asbury, CEO, NEFHS explained that the average collection rate for NEFHS for their more than 17,000 patients is $113.00 from all of their carriers combined, for their entire service area.

5:32 p.m. Commissioner John Hill left the meeting.

Ms. Asbury continued by explaining to the Board that NEFHS submitted their request for funding for 2019-2020 dates back in April of 2019, projecting what they believed that utilization would add up to. Her team has since reviewed the current year utilization and in an attempt to save tax payer dollars, they are willing to reduce their primary care application for funding from $1,148,921.00 down to $918,322.00, with last year's Medicaid rate of reimbursement of $120.43 (less the $5 copay at $115.43 except for prenatal services) per visit, absorbing the prenatal services funding request of $38,700.00 into their primary care services funding and reducing their pharmacy funding request from $1,000,320.00 down to $752,281.00, reducing their overall WVHA 2019-2020 funding request by $517,335.00.

Motion 099 – 2019 Commissioner Ferrari motioned to approve funding the NEFHS consolidated clinics at $918,322.00, with a rate of reimbursement of $120.43 (less $5 copay for primary care services at $115.43) including prenatal services in this funding agreement and at the full rate of reimbursement of $120.43 (not assessing the $5 copay for prenatal services). Commissioner Manning seconded the motion. The motion passed by a 4-0-1 vote.

Motion 100 – 2019 Commissioner Ferrari motioned to approve funding the NEFHS Pharmacy Agreement at $752,281.00 for 2019-2020. Commissioner Guzman seconded the motion. The motion passed by a 4-0-1 vote.

Commissioner Ferrari asked Ms. Maureen France, EMPros to address the Board regarding the Fourteenth Addendum Primary Care Physicians Indigent Hospital Patient Funding Agreement.

Ms. Maureen France addressed the Board explaining that EMPros and Advent Hospitals were both in agreement that $175,000.00 of the $225,000.00 funding would be appropriated to EMPros services. She explained that EMPros would not be able to draw down that $175,000.00 at the current flat fee of $68.42 for emergency department services.

Mr. Small responded that he was given very clear directives from the WVHA Board to draft this agreement as it had been drafted in the past, only allocating $175,000.00 of the $225,000.00 funding to EMPros. There was no Board directive to change the rates of reimbursements.

Ms. France explained that EMPros averages 1,600 to 1,800 WVHA patients per year and at $68.42 they cannot draw down the full amount of $175,000.00.

Mr. Small asked if EMPros was giving the WVHA the best rate that they charge any other payer, private, public or any other payer, including from the hospitals?

Ms. France explained that EMPros does not get paid by the hospitals, they have a contract to provide emergency medical services for the patients at the hospitals, they receive no stipend or financial remunerations at all. In their application for WVHA funding they listed what they receive from commercial payers of $358.00, Medicare pays $143.00, and Medicaid pays $82.00. EMPros is receiving the lowest rate of reimbursement from the WVHA. EMPros just wants what is fair and being reimbursed at lower than the Medicaid rate of reimbursement does not appear fair.

Commissioner Ferrari requested that the Fourteenth Addendum be brought back for Board consideration during the November meeting, to allow time for the rate of reimbursement to be reconsidered and further negotiated.

Commissioner Guzman addressed all the agency representatives present and asked them to be more responsive to Attorney Small when he asks for additional information.

There was Board consent to bring back the Fourteenth Addendum during the November Board Meeting.

WVHA Investment Policy Statement October 17, 2019

Motion 101 – 2019 Commissioner Ferrari motioned to accept the WVHA Investment Policy Statement dated October 17, 2019. Commissioner Guzman seconded the motion. The motion passed by a 4-0-1 vote.

EBMS/Veracity Proposal

Motion 102 – 2019 Commissioner Ferrari motioned to move forward with the EBMS/Veracity proposal in concept and subject to a final written contract, authorizing Attorney Small to negotiate an agreeable contract with EBMS/Veracity. Once agreement has been reached, Attorney Small is further authorized to submit notice of termination to UMR before November 1, 2019. Commissioner Guzman seconded the motion. The motion passed by a 4-0-1 vote.

Follow Up Items

SMA Baker Act WVHA Verification Forms (attached)

Mr. Tore Gintoli, SMA addressed the Board and asked if they found the verification forms presented as acceptable?

Mr. Small stated that he found the verification forms as revised by SMA Baker Act acceptable as to form.

Finance Report

Mr. Ron Cantlay, DRT reviewed for the Board the September financial statements (see attached).

Motion 103 - 2019 Commissioner Guzman motioned to pay the bills totaling $2,191,122.98. Commissioner Manning seconded the motion. The motion passed by a 4-0-1 vote.

Legal Update

Mr. Theodore Small, Legal Counsel for the WVHA submitted his legal update memorandum dated October 8, 2019 (See attached).

Commissioner Comments

There being no further business to come before the Board, the meeting was adjourned.

Adjournment

Judy Craig, Chair

UMR

November 21, 2019

Submission Report for WVHA Board Members

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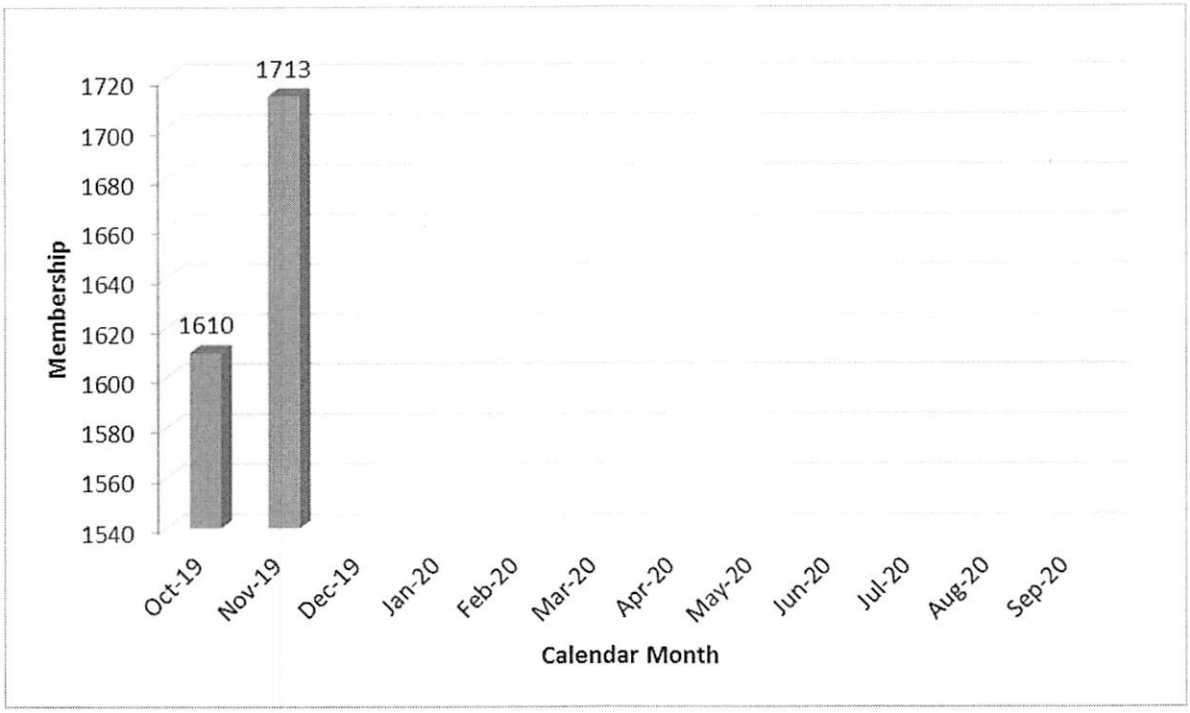
WVHA Health Card Program Eligibility – by Calendar Month – as of November 1, 2019

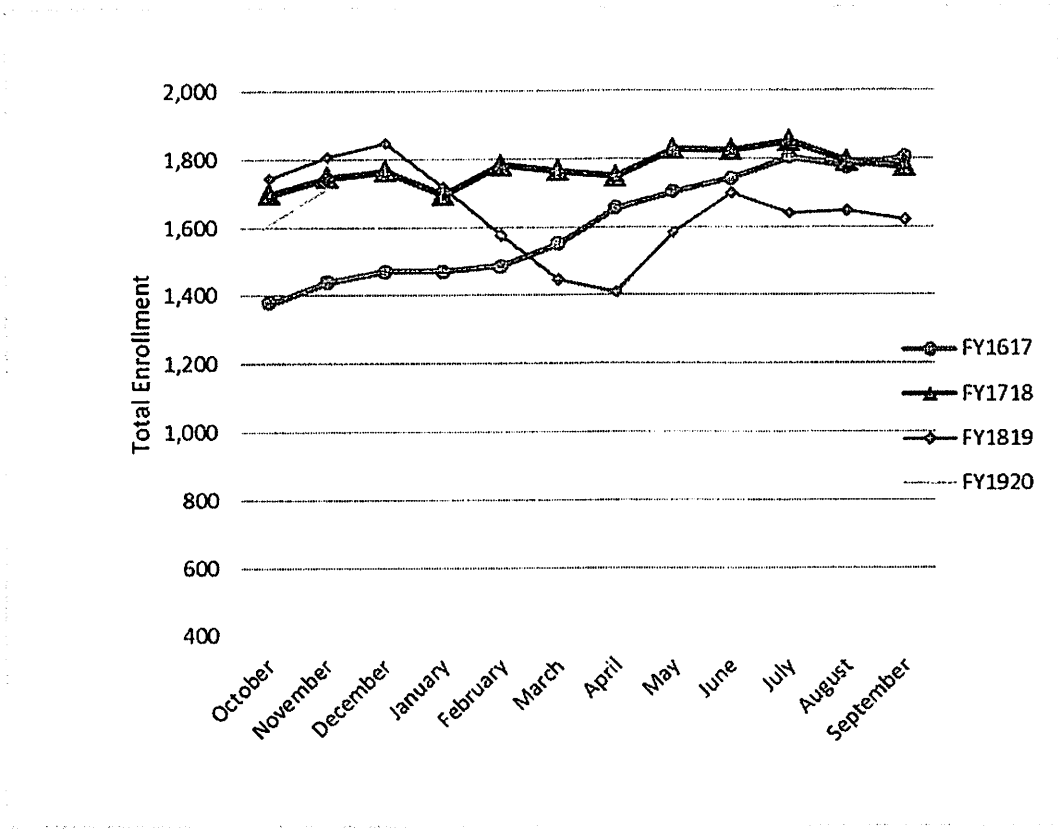
Eligibility reported above reflects eligibility as of the first of each month.



As of November 1, 2019, total program eligibility was 1713 patients.

WVHA Enrollment by Fiscal Year – as of November 1, 2019

WVHA Enrollment By Fiscal Year	
Month of Fiscal Year	FY1920
October	1,610
November	1,713
December	
January	
February	
March	
April	
May	
June	
July	
August	
September	
Grand Total	3,323


2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
Total Enrollment
October
November
December
January
February
March
April
May
June
July
August
September
FY1617
FY1718
FY1819
FY1920

WVHA Enrollment by Zip Code – as of November 1, 2019

WVHA Enrollment by Zip Code by Month							
Zip Code	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
32102	5	5	5	5	4	4	3
32130	62	62	53	53	53	48	51
32180	106	106	97	98	95	93	97
32190	19	19	20	22	23	24	21
32706	2	2	2	2	2	2	1
32713	64	64	60	64	62	66	71
32720	362	362	327	337	334	344	381
32721	4	4	3	3	3	4	4
32724	285	285	286	289	281	262	292
32725	334	334	336	331	333	327	329
32728	3	3	3	4	4	4	4
32732	1	1	0	0	0	0	0
32738	294	294	288	278	275	275	288
32744	26	26	25	24	26	25	28
32753	1	1	1	1	1	1	1
32759	1	1	1	1	0	0	0
32763	113	113	112	113	104	104	113
32764	15	15	15	15	14	13	13
32774	3	3	2	2	2	2	2
32762	1	0	0	0	0	0	0
32763	107	113	112	113	104	104	113
32764	13	15	15	15	14	13	13
32774	3	3	2	2	2	2	2

Medical and Prescription Drug Claim Data

Pharmacy Claims by Fiscal Year by Service Month (Month Prescription Filled)

	FY1819				
Month	Drug Costs	Dispensing Fee Less Copayments	Total Costs	Total Rx's Filled	Avg Cost Per Rx
October	$55,005.45	$7,661.22	$62,666.67	3,451	$18.16
November	$55,658.13	$7,008.54	$62,666.67	3,157	$19.85
December	$85,000.00	$4,502.16	$89,502.16	2,027	$44.15
January	$66,232.60	$4,930.62	$71,163.22	2,221	$32.04
February	$53,124.87	$5,151.28	$58,276.15	2,324	$25.08
March	$35,517.40	$4,886.40	$40,403.80	2,220	$18.20
April	$128,722.39	$5,223.66	$62,690.09	2,353	$26.64
May	$117,732.26	$5,170.39	$62,690.09	2,329	$26.92
June	$57,473.09	$5,217.00	$62,690.09	2,329	$26.92
July	$120,878.79	$5,170.38	$62,690.09	2,329	$26.92
August	$117,546.25	$6,978.00	$62,690.09	2,326	$26.96
September	$90,541.58	-$1,423.50	$89,118.08	1,825	$29.58
Grand Total	$983,432.81	$60,476.15	$787,247.20	28,891	$27.25

Combined Medical Costs (as of Claims Payment through 10/24/2019)

Medical and pharmacy costs are reported on a paid basis

Fiscal Year	Hospital	Lab	PCP	Specialty	Facility Physicians	Pharmacy	Total Costs	Member Months	Overall Per Member Per Month (PMPM)	Hospital PMPM	Lab PMPM	PCP PMPM	Specialty PMPM	Pharmacy PMPM
FY1920	**-$339,593.22**	**$40,888.46**	**$110,883.43**	**$321,160.59**	**$0.00**	**$0.00**	**$133,339.26**	**1,713**	**$77.84**	**-$198.24**	**$23.87**	**$64.73**	**$187.48**	**$0.00**
October	-339593.22	40888.46	110883.43	321160.59	0		$133,339.26	1,713	$77.84	-$198.24	$23.87	$64.73	$187.48	$0.00
November														
December														
January														
February														
March														
April														
May														
June														
July														
August														
September														
Grand Total	**-$339,593.22**	**$40,888.46**	**$110,883.43**	**$321,160.59**	**$0.00**	**$0.00**	**$133,339.26**	**1,713**	**$77.84**	**-$198.24**	**$23.87**	**$64.73**	**$187.48**	**$0.00**

PCP Encounter Claims by Clinic by Month (as of Claims Payment through 10/24/2019)

	FY1920					
Month	NEFHS Deland	NEFHS Deltona	NEFHS Pierson	NEFHS Stone Street	NEFHS Daytona	Total
October	278	334	116		13	741
November						0
December						0
January						0
February						0
March						0
April						0
May						590
June						0
July						0
August						0
September						0
Grand Total	278	334	116	0	13	1,331

PCP encounter claims are reported on a paid basis

Specialty Care Services by Specialty – Top 25 (October, 2019)

SPECIALTY CARE SERVICES BY SPECIALTY - TOP 25 FOR October							
Order	SPECIALTY	Unique Patients	Claim Volume		Paid		Cost Per Patient
1	Oncology	32	74	$	61,118.60	$	825.93
2	Hematology Oncology	30	75	$	38,738.15	$	516.51
3	Internal Medicine	65	124	$	33,536.94	$	270.46
4	Cardiovascular Diseases	55	84	$	20,789.10	$	247.49
5	Surgery Center	28	31	$	20,075.64	$	647.60
6	Radiology	243	418	$	18,173.19	$	43.48
7	Obstetrics & Gynecology	31	47	$	13,978.36	$	297.41
8	Gastroenterology	66	93	$	13,734.24	$	147.68
9	Pain Management	42	55	$	11,027.92	$	200.51
10	Anesthesiology	32	36	$	10,575.10	$	293.75
11	Physical & Occupational Therapy	29	124	$	8,588.26	$	69.26
12	Nurse Anesthetist	48	53	$	7,299.24	$	137.72
13	Pulmonary Medicine	32	83	$	7,277.35	$	87.68
14	General Surgery	9	14	$	6,465.10	$	461.79
15	Ophthalmology	34	42	$	6,378.93	$	151.88
16	Orthopedic Surgery	48	65	$	6,106.43	$	93.95
17	Family Practice	42	74	$	5,117.70	$	69.16
18	Nurse Practitioner	44	52	$	4,179.33	$	80.37
19	Infectious Diseases	21	35	$	4,028.29	$	115.09
20	Cardiology	19	25	$	2,942.51	$	117.70
21	Optometry	22	35	$	2,926.53	$	83.62
22	Counselor / Therapist	23	38	$	2,864.34	$	75.38
23	Urology	19	24	$	2,803.41	$	116.81
24	Podiatry	14	25	$	2,797.87	$	111.91
25	Neurology	25	27	$	2,213.10	$	81.97

Additional Item

Subrogation Lien Reduction Request

UMR has been working on a subrogation case regarding a WVHA health card member claims from the POMCO platform that have confirmed third party liability.

In our attempt to recover the funds for WVHA, the heath card member's attorney is requesting that WVHA reduce the liability by 1/3.

As a reminder, on subrogation cases we normally see a request for a 1/3 reduction on the lien whenever a member has employed an attorney with the goal of keeping as much of the third party settlement in the hands of the member/plaintiff. The decision however is always up to the program sponsor.

POLITIS & MATOVINA P.A.

Established 1993 TheJusticeAttorneys.com

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Stephanie Ciescere
Amanda Shaw
Gabriella Vitrano-Bell
Roxy Rivera

August 21, 2019

POMCO (160624)
Attn: Kimberley E. Bigos
P.O. Box 6329
Syracuse, NY 13217

Via Facsimile 844-690-9209

RE: Our Client:
Social Security Number:
Date of Birth:
Date of Accident:
Your File Number:

Dear Ms. Bigos:

As you know, our office represents the above party with regard to the above referenced claim. Kindly be advised that my client's personal injury claim has been settled and/or resolved as of August 20, 2019 with Broadspire Services for 7-Eleven.

Please also consider this our formal request for a lien reduction of 1/3 of your lien. As requested, please be advised of the following:

- Total Settlement $42,000.00
- Attorney's Fees $14,000.00
- Costs $ 509.13
- Outstanding Medical $ 6,199.53 (This does not include your lien)

It is imperative that we hear back from you as soon as possible and no later than (30) thirty days from today. The proceeds of this case will be released at that time and if we do not have a response by then, we will assume that you have agreed to waive the lien.

If you have any questions or need any additional documentation, please don't hesitate to contact my office. Thanking you for your time and courtesy in this matter, I remain,

Very Truly Yours,

POLITIS & MATOVINA, P.A.
By: Mark A. Matovina, Esquire

MAM/dh
cc: Tosha Decker

POMCO
EXPERIENCE EXCELLENCE

2425 James Street
Syracuse, NY 13206
Telephone: 315.937.2873
Facsimile: 844.690.9209

July 31, 2019

Mr. Mark Matovina
Politis & Matovina, PA
1200 N. Volusia Avenue
Orange City, FL 32763

VIA FACSIMILE
386-775-1994

Re: West Volusia Hospital Authority Health Plan
Member:
Member ID:
D/A: 7/10/16

Dear Mr. Matovina:

We have received your letter of July 10, 2019 relating to the above accident.

The West Volusia Hospital Authority Health Plan is self-funded and contains an exclusion for payments received as the result of a "Third Party Claim or Settlement." By definition, a "Third Party Claim" is when you receive payment or are reimbursed as the result of legal action or settlement for services or supplies obtained in connection with an accidental injury. Therefore, the plan must be reimbursed for the expenses it incurred relating to Ms. Decker's accident of July 10, 2016. The plan administered by POMCO has paid $4,300.02. Please be advised the plan which is presently administered by UMR may have also paid related claims. You may contact subrogationreferrals@optum.com for information relating to a potential UMR lien.

If you need additional information, please contact me.

Sincerely,

Kimberley E. Bigos

Kimberley E. Bigos

/kb

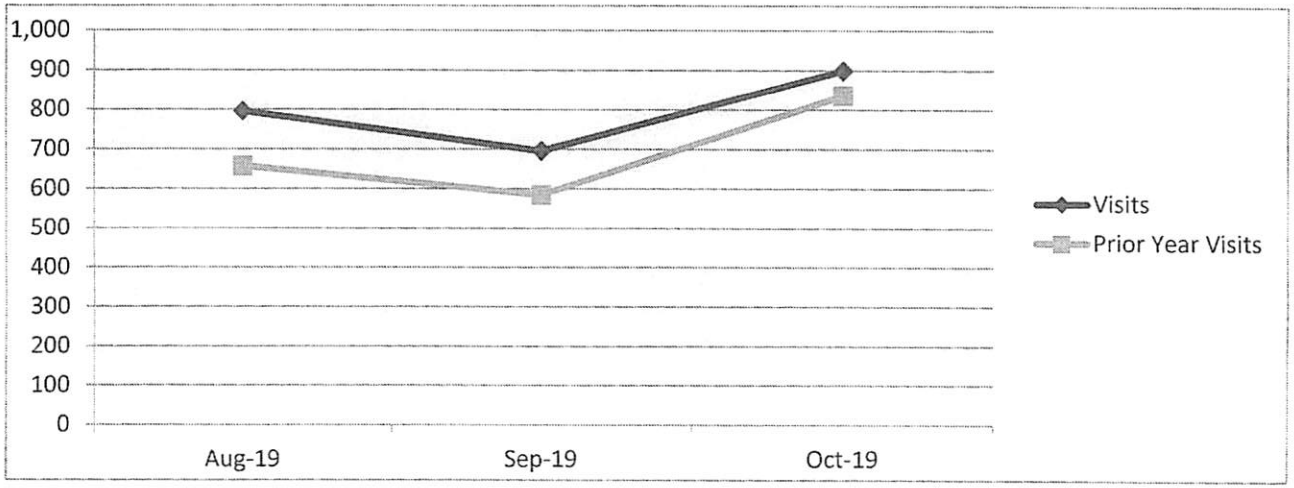
FAMILY Health Source

Northeast Florida Health Services

October-19

Patient Visits

	Aug-19	Sep-19	Oct-19
Visits	796	696	899
Prior Year Visits	658	585	836



Patient Visits by Location

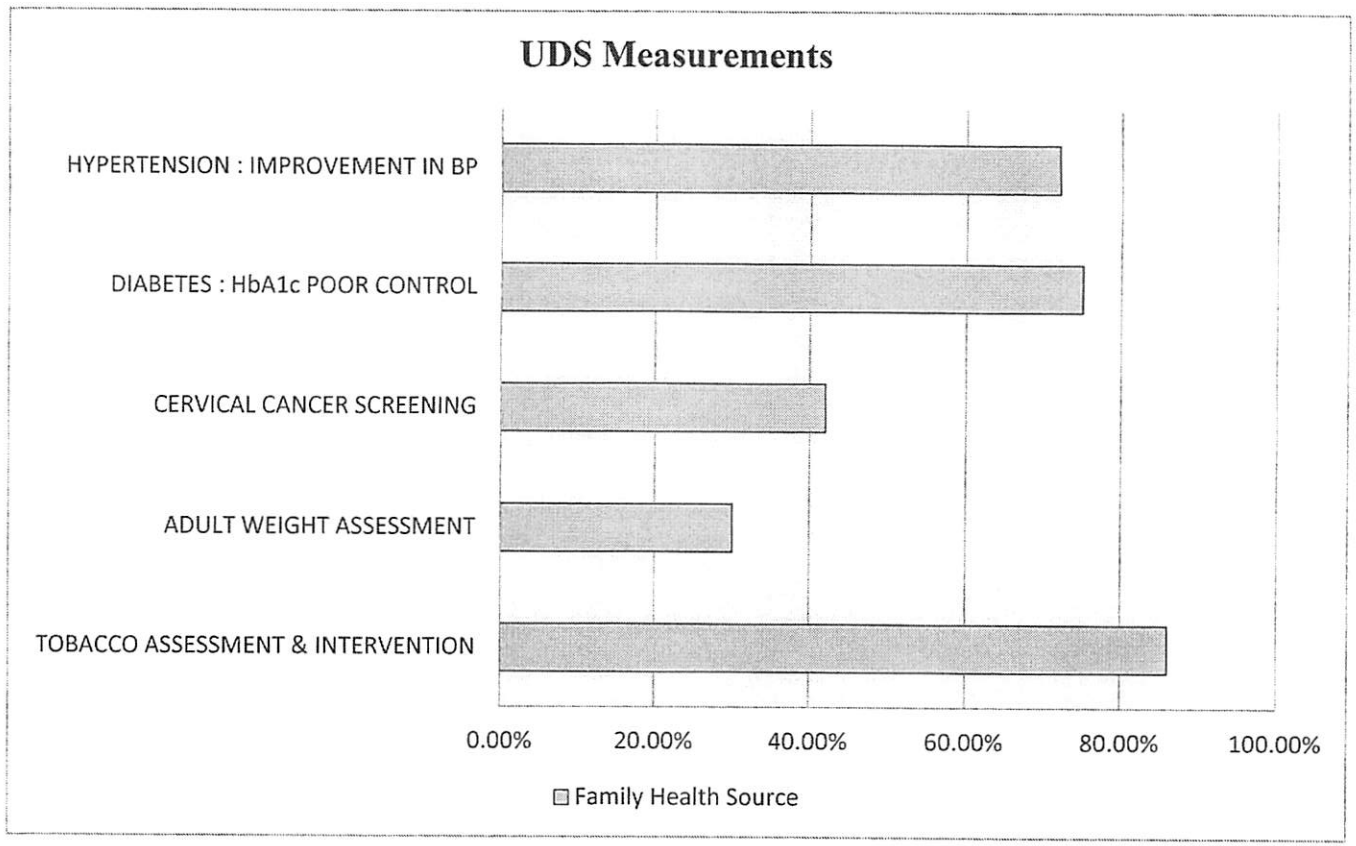
Location	Aug-19	Sep-19	Oct-19
Deland Medical	364	280	374
Deltona Medical	296	274	351
Pierson Medical	123	132	161
Daytona	13	10	13
Total	796	696	899

Appointment Times

Location	Provider	Appointments
Daytona	Johnson	Same Day
Daytona	Fuller	Same Day
DeLand	Fabian	Same Day
DeLand	Smith	Same Day
DeLand	Sauls	Same Day
DeLand	Sanchez	Same Day
Deltona	Rodriguez	Same Day
Deltona	Mancini	Same Day
Deltona	Koback	Same Day
Pierson	Hoblick	Same Day
Pierson	Roberson	Same Day

UDS Measures

Clinical Measures for the month of October 2019	Family Health
TOBACCO ASSESSMENT & INTERVENTION	86.00%
ADULT WEIGHT ASSESSMENT	30.00%
CERVICAL CANCER SCREENING	42.00%
DIABETES : HbA1c POOR CONTROL	75.00%
HYPERTENSION : IMPROVEMENT IN BP	72.00%



FAMILY Health Source

"GROWING WELLNESS IN OUR COMMUNITIES"

Pierson
216 N. Frederick St.
Pierson, FL 32180
(386) 749-9449
Fax: (386) 749-9447

Deltona
2160 Howland Blvd.
Deltona, FL 32738
(386) 532-0515
Fax: (386) 532-0516

DeLand
844 W. Plymouth Ave.
DeLand, FL 32720
(386) 738-2422
Fax: (386) 738-2423

Daytona
801 Beville Rd.
Daytona Beach, FL 32119
(386) 267-6214
Fax: (386) 999-0414

Pediatrics
800 W. Plymouth Ave.
DeLand, FL 32720
(386) 736-7933
Fax: (386) 736-7934

Pharmacy
1205 S. Woodland Blvd,
Ste. 5
DeLand, FL 32720
(386) 888-4912
Fax: (386) 269-9950

Administration
1205 S. Woodland Blvd,
DeLand, FL 32720
(386) 202-6025
Fax: (386) 269-4149

www.familyhealthsource.org
Non-Profit Federally Qualified Health Center of Northeast Florida Health Services, Inc.

WVHA Prescription Audit- July 2019- Sept-2019

	July-19	Aug-19	Sept-19	Total
Total Scripts:	2344	2320	1825	6489
Script Sample:	20	20	20	60
Specialist Scripts:	4	1	2	7
Total Acute Scripts:	7	2	3	12
Total Chronic Scripts:	15	14	12	41
Total Rx filled correctly:	20	20	20	60
Total Scripts filled in error:	0	0	0	0

*All __41__ chronic scripts written and filled for 90 days or more

Nurturing Families
Building Communities

The House Next Door
Serving
Volusia and Flagler Counties

Administrative Offices 804 North Woodland Blvd. DeLand, FL 32720
386-734-7571
386-734-0252 (fax)

DeLand Counseling Center
121 W. Pennsylvania Ave.
DeLand, FL 32720
Counseling: 386-738-9169
Programs: 386-734-2236
386-943-8823 (fax)

Deltona Counseling Center 840 Deltona Blvd., Suite K Deltona, FL 32725
Counseling and Programs:
386-860-1776
386-860-6006 (fax)

Flagler Counseling Center
25 N Old Kings Road #7B
Palm Coast, FL 32137
386-738-9169
386-943-8823

S. Daytona Counseling Center
1000 Big Tree Road Daytona Beach, FL 32114 386-301-4073
386-492-7638 (fax)

November 5, 2019

West Volusia Hospital Authority

Monthly Enrollment Report

In the month of September there were 365 appointments to assist with new applications and 74 appointments to assist with pended applications from September-October. for a total of 439 face to face contact with clients.

361 applications were submitted for verification and enrollment. Of these, 300 were processed by the end of the month (includes the roll overs -11- from previous month) leaving the balance of 72 to roll over into November for approval.

Of the 300 that were processed, 281 were approved and 15 were denied. The remaining 4 were pended and letters were sent out to the clients.

Currently applications are being processed, approved and the client enrolled in 7 business days. Please note it takes up to five days once we enter the data into the UMR system for the client to be enrolled.

Respectfully submitted by Gail Hallmon

EMPLOYEE BENEFIT MANAGEMENT SERVICES, LLC

ADMINISTRATIVE SERVICES AGREEMENT

for

WEST VOLUSIA HOSPITAL AUTHORITY

EMPLOYEE BENEFIT MANAGEMENT SERVICES, LLC

ADMINISTRATIVE SERVICES AGREEMENT

THIS Administrative Services Agreement ("Agreement") is entered into effective this 1st day of January, 2020, by and between, West Volusia Hospital Authority, a special tax district established under the laws of the State of Florida, hereinafter referred to as the "Authority," and Employee Benefit Management Services, LLC, of 2075 Overland Avenue, Billings, Montana 59102, hereinafter referred to as the "Contract Administrator."

WHEREAS, The Authority was established by special act of the Florida Legislature, Chapter 57-2085 for the purpose of taxation and establishing a program whereby certain medical treatments and services for the benefit of qualified indigent residents of Volusia County, Florida, (each a "Member"), as well as other related activities, including the promotion of the general health of the tax district, (hereafter the program operated by the Authority will be referred to as the "West Volusia Hospital Authority Healthcare Program" or "Health Plan"); and

WHEREAS, The Authority desires to engage the services of the Contract Administrator to provide certain medical claim administration services in relation to the Health Plan, as enumerated below;

NOW, THEREFORE, in consideration of the mutual covenants and conditions contained herein, the parties hereto agree as follows:

SEC. I DUTIES AND RESPONSIBILITIES OF AUTHORITY

1.01 The Authority shall at all times retain ultimate discretionary authority and all final authority and responsibility for the Health Plan and its operation. The Authority delegates to Contract Administrator only non-discretionary authority to assist the Authority in the development, maintenance and administration of the Health Plan as specifically described in this Agreement or as mutually agreed to in writing. Any function not expressly delegated by Authority to, and formally assumed by Contract Administrator in writing pursuant to this Agreement shall remain the sole responsibility of Authority.

1.02 The Authority retains sole rights and responsibility to develop the Health Plan in a manner that complies with all applicable state and federal laws and their implementing regulations. Authority agrees that compliance of the Health Plan is the sole responsibility of the Authority and it will secure legal and/or professional review of this Agreement as well as other supporting materials and documents as a part of its obligations hereunder.

1.03 The Authority or its designee (not Contract Administrator) will be solely responsible to make determinations of eligibility and coverage under the Health Plan and benefits to be paid by the Health Plan with the express exception of the amount of any claim where the amount to be paid is clear and unambiguous and may be performed exercising only the ministerial powers of the Contract Administrator.

1.04 The Authority shall have final authority as to the investment (if any) and use of any assets to fund the Health Plan.

1.05 The Authority shall be responsible for funding the Health Plan and Account (as hereinafter defined), in a manner for which benefits may be paid timely.

1.07 The Authority or its designee (not Contract Administrator), shall be responsible for taking the following actions to facilitate the proper performance of the Contract Administrator's responsibilities:

(a) provide the Contract Administrator with a complete and accurate list of all individuals eligible for benefits under the Health Plan, by online entry of such information or by such other method as the parties may agree from time to time prior to the Effective Date. Authority states that Contract Administrator may rely upon the eligibility information supplied and will hold Contract Administrator harmless against errors resulting from or related to inaccuracies in eligibility information;

(b) notify the Contract Administrator, no less than monthly, of any changes in eligibility and

participation. Notice of Health Plan Member termination must be given within thirty (30) days of the termination. Under no circumstances shall credits for administrative fees be retroactive;

(c) review and approve all eligible Health Plan Members (and return to Contract Administrator when necessary) all appropriate and necessary materials, documents, forms, applications as may be necessary for the operation of the Health Plan or to satisfy the requirements of State or Federal laws or regulations (collectively, "Documents");

(d) provide the Contract Administrator with copies of any and all revisions or changes to the Documents as soon as is reasonably known, but no later than forty-five (45) days before the effective date of the changes, or as otherwise required under applicable law;

(e) satisfy any and all required reporting, required responses, and disclosure requirements imposed by law and/or solicited from any and all governmental authorities;

(g) provide the Contract Administrator with any additional information incidental to the Health Plan, as may be requested by the Contract Administrator from time to time;

1.09 Except as required to be disclosed by the Florida Public Records Law (Fla. Sta.t § 119.01 et. seq.) or other applicable law, Authority shall hold information that is proprietary to Contract Administrator confidential ("Confidential Information") and shall not use or disclose such information without the consent of Contract Administrator. Confidential Information shall include ideas, concepts, techniques, works of authorship, know-how, finances, development plans, current or proposed products or services, processes, pharmacy benefit management arrangements, client lists, including prospective clients, employees, business relationships, fee schedules, provider reimbursement, and information of third parties that is subject to separate confidentiality protections, (whether transferred orally, in writing, visually, electronically or by any other means) furnished (whether before or after the date hereof) by Contract Administrator to the Authority with written notice that it is being provided on a confidential basis. Confidential Information shall not include information that: (i) is or becomes publicly available other than as a result of a disclosure by a party, (ii) is or becomes available to a party on a non-confidential basis from a source (other than a party to this Agreement) which is not prohibited from disclosing such information to another party by a legal, contractual or fiduciary obligation, (iii) is independently developed by a party to this Agreement as demonstrated by written or documented evidence, (iv) was known by a party to this Agreement prior to disclosure for this Agreement; (v) or all records and files that the Contract Administrator generates in conjunction with the administrative services to be performed hereunder as defined in Section 6.01.

Unless required by law to do otherwise, Authority shall deliver prompt, reasonable and written notice to the Contract Administrator and where practicable such notice shall be given in advance of the Authority fulfilling any public records request that would involve the production of "Confidential Information" of Contract Administrator. Such notice shall at a minimum describe the scope and nature of the request, specify the requestor and information proposed for disclosure and/or already disclosed, as applicable. Notice given under this subsection shall be directed to the following address:

Employee Benefit Management Service, LLC
2075 Overland Avenue
P.O. Box 21367
Billings, MT 59104-1367
C/O Corporate Counsel

SEC. II DUTIES AND RESPONSIBILITIES OF THE CONTRACT ADMINISTRATOR

2.01 The Contract Administrator agrees to perform the following administrative services for the Authority:

(a) assist in the preparation, printing and distribution to Health Plan Members of identification cards, SPDs and other material necessary to the operation of the Health Plan;

(b) process and adjudicate all claims presented for payment in accordance with the controlling

benefit documents;

(c) respond to inquiries from the Authority, Members and service providers concerning requirements, procedures or benefits of the Health Plan, though such information shall not constitute a determination of benefits that will be paid under the Health Plan or a guarantee or certification to anyone that any amount will be paid;

(g) maintain all claim files for the Health Plan in accordance with portion of this Agreement entitled "Records;"

(h) Prepare and provide monthly reports of contributions received from the Authority and all disbursements made from the Health Plan. Standard reports that can be produced by the automated claims system in use by the Contract Administrator, will be available to the Authority. Contract Administrator shall provide these reports to the authorized individuals designated by Authority to receive and disclose the protected health information of Members. Authority shall have full responsibility to ensure its designated Health Plan representatives use and disclose this confidential protected information in a manner consistent with the requirements of HIPAA and other applicable laws, as amended. Unless required by law, under no conditions will the Authority use the information provided in any manner that could jeopardize an individual's privacy or inconsistent with its role as the Authority and Health Plan Administrator;

(i) provide the Authority with an annual summary report of the operation of its Health Plan;

(j) provide information necessary for the Authority to prepare reports required by any local, state or federal government pertaining to the operation of the Health Plan. Additional compensation shall be negotiated between the parties for any reports or information requested or required by Authority to respond to document requests made in the course of a government investigation or audit or a court proceeding (including but not limited to a subpoena and document requests) or to an agency or court order;

(k) provide agreed upon electronic files of Authority's data in standard file formats and in exchange for a standard maintenance fee. If Authority requests that Contract Administrator provide an electronic file to Authority's third party vendor for which Contract Administrator does not have a standard file format or that Contract Administrator provide a customized file format for its vendor partner, Contract Administrator will assess Authority the custom EDI file format fee and the custom maintenance fee. A custom EDI file format fee will be assessed to Authority for each request of Authority's third party vendor to change the custom file extract.

(l) maintain bank account(s) in the name of the Contract Administrator, in a financial institution mutually agreed upon by the Health Plan Sponsor and Contract Administrator, from which checks or drafts are issued to cover expenses of the Health Plan, hereinafter referred to as the, "Account".

2.02 Contract Administrator shall cooperate with the Authority in the defense of any action arising out of matters related to the Health Plan, and make available to Authority and its counsel, documentation relating to or relevant to the action as Contract Administrator may have as a result of the performance of its obligations under this Agreement. The defense of any legal action or proceeding brought to recover a claim for benefits or other matter involving the Health Plan shall not be the obligation of the Contract Administrator, and all fees, expenses or costs attributable to the defense shall be the sole responsibility of Authority. In the event that Contract Administrator pays any such fees and costs, either for its own defense or to support the defense of Authority, Authority shall immediately reimburse Contract Administrator and the remedies of Section 3.03 shall apply.

2.03 Contract Administrator and Authority agree that any and all functions performed by Contract Administrator on behalf of the Authority do not give rise to or result in Contract Administrator acting as a "fiduciary" of the Health Plan. Both parties agree that the Contract Administrator is not a fiduciary of or for the Health Plan; that Contract Administrator does not have discretionary authority or discretionary control with respect to the management of the Health Plan; that Contract Administrator does not exercise any authority or control with respect to the management or disposition of the assets of the Health Plan; that Contract Administrator does not render

investment advice; and with respect to the foregoing, the Contract Administrator has no authority or responsibility to do so.

SEC. III FEES OF THE CONTRACT ADMINISTRATOR

3.01 The Contract Administrator shall receive consideration in accordance with Schedule A herein incorporated by reference or as otherwise specifically denoted on another Schedule.

3.02 The Administrative Fees must be received by the Contract Administrator on or before the 10th day of the month for which they are due. The Administrative Fees described in Schedule A are payable in advance and may be deducted from the proceeds transferred by the Authority to Contract Administrator's Account.

3.03 If the Authority, for any reason whatsoever, fails to make a required fee payment by the 30th day of the month in which it is due, the Contract Administrator may:

(a) after written notice to Authority and the Authority fails to make the required fee payment within fifteen (15) days after such written notice is delivered, suspend the performance of its services to the Authority until such time as the Authority makes the proper remittance;

(b) charge interest to the Authority on all past due fees at the rate of one and one-half percent (1½%) per month or the maximum rate allowed by law, whichever is less;

(c) cease retroactively to the end of the month for which full payment was last received, all administrative services; and/or

(d) commence termination of this Agreement in accordance with Section VIII.

3.04 In the event Contract Administrator advances any sums to a vendor or a state and/or federal agency on behalf of the Authority, Authority agrees to immediately reimburse Contract Administrator in full and the remedies in Section 3.03 will apply. This provision shall survive the termination of this Agreement.

3.05 If the number of participants enrolled in the Health Plan decreases by twenty-five percent (25%) or more when compared to the number of participants enrolled as of the first day of each year of the Initial Term or a subsequent Renewal Term, Contract Administrator shall have the right to prospectively adjust its administrative fee. Contract Administrator shall provide notice to the Authority of the change in its administrative fee at least thirty (30) days prior to the effective date of such change. The written notice shall describe the change and the effective date thereof, and explain the Authority's right to reject the change and terminate the Agreement without penalty. If such change is unacceptable to the Authority, either party shall have the right to terminate the Agreement without penalty by giving written notice of termination to the other party before the effective date of the change. If Authority accepts the proposed change, Contract Administrator shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Authority's signature on the Schedule. If Authority fails to respond to the notice and does not terminate the Agreement during the notice period, Authority will be deemed to have approved the proposed changes and Contractor Administrator shall provide a revised Schedule A that will then become part of this Agreement without the necessity of securing Authority's signature on the Schedule. An adjustment to Contract Administrator's administrative fee pursuant to Section 3.05 shall take effect the first of the month following the date of notice to Authority, unless the parties agree otherwise. The adjustment may be made regardless of any rate guarantee that may be in place for that period of time. Failure by the Authority to pay the adjusted administrative fee is subject to remedies of Section 3.03.

3.06 The Contract Administrator shall not provide or be responsible for the expenses and cost of legal counsel, actuaries, certified public accountants, consulting physicians, consulting dentists, medical and other review charges for special claims investigations, independent medical review services or similar services performed for the Authority.

SEC. IV CLAIMS PAYMENT

4.01 On a bi-weekly basis, or as otherwise directed by the Authority, the Contract Administrator shall

provide a list of claims approved for payment under the Health Plan. The Authority shall deposit sufficient funds in the Account to cover the approved claims within five (5) business days. The Contract Administrator shall issue checks from the Account to pay approved claims.

4.02 If the Authority, for any reason whatsoever, fails to deposit sufficient funds in the Account within twenty (20) business days from the date requested by the Contract Administrator, or if the Contract Administrator has reasonable concerns regarding the Authority's ability to sufficiently fund claims, the Contract Administrator may immediately, with prior notice to the Authority, suspend all claims paying activities, issue notices as necessary and/or take other necessary action until sufficient and timely funding of the Account is established.

4.03 Contract Administrator has no financial responsibility to the Authority, or any other party, to pay for any professional, hospital or other bills related to a Member. Authority will resolve billing and administrative issues directly with Providers after the Contract Administrator has verified that it has performed all of its administrative services to be performed hereunder related to processing payments to the subject Provider(s). Upon request, the Contract Administrator will facilitate communications between Provider and Authority to resolve billing and administrative issues.

SEC. V LIMITS OF THE CONTRACT ADMINISTRATOR'S RESPONSIBILITY

5.01 If a claim adjudication error should be discovered, the Contract Administrator shall use commercially reasonable efforts toward the recovery of any loss therefrom, and in cases of overpayments, Contract Administrator's reasonable efforts toward a recovery will include reasonable efforts under industry standards, including at least three attempted communications aimed at correcting the overpayment. Contract Administrator shall not be required to supply legal services or initiate legal proceedings for any such recovery and shall have no liability for such errors, provided they are reasonable, made in good faith, and within acceptable industry standards.

5.02 It is understood and agreed that the Contract Administrator is, and shall remain, an independent contractor with respect to the services being performed and shall, for no purpose, be deemed an employee or fiduciary of the Authority.

5.03 It is understood and agreed that the Contract Administrator is not a "Plan Sponsor", "Plan Administrator" or "Fiduciary" of or for the Health Plan as such terms are defined by any law applicable to qualified employee insurance plans or insurance plans generally which should not apply to the Health Plan, which is a discretionary local government welfare benefit plan. Notwithstanding anything in the Agreement to the contrary, any delegation of authority or duties pursuant to this Agreement construed by a court of law or governmental agency to make the Contract Administrator such a Plan Administrator or fiduciary shall be null and void, and such duties are hereby retained by the Authority. Accordingly, the services to be performed by Contract Administrator shall be limited to the ministerial services set forth in this Agreement and the performance by Contract Administrator of such services shall be subject to review by the Authority.

5.04 It is further understood by the Authority that the Contract Administrator is not a custodian or an insurance company, and that the Contract Administrator shall have no responsibility, risk, liability or obligation for the funding of the Health Plan. The responsibility and obligation for funding the Health Plan shall be solely and totally the responsibility of the Authority. Contract Administrator shall have no final discretionary authority or control over the management or disposition of Health Plan assets, and no authority over, or responsibility for, Health Plan administration. Contract Administrator is neither the Authority or Health Plan Administrator, nor a provider of health care services. Contract Administrator shall have no responsibility for any insurance coverage relating to the Health Plan, Health Plan Members, or Authority; or the nature or quality of professional health services rendered to Health Plan Members.

5.05 Contract Administrator and the Authority shall each be solely responsible for compliance with all laws, rules and regulations that are now or hereafter applicable to each of them and their own roles and performance under this Agreement. Contract Administrator shall not be responsible for establishing or maintaining the Health Plan or ensuring the Authority is in compliance with applicable State or Federal legal requirements, nor shall Contract Administrator be an entity that is responsible for payment under the Health Plan or for payment of any fees, assessments, penalties or taxes, regardless of whether such fees, assessments, penalties or taxes are assessed against the Health Plan, the Authority, or the Contract Administrator on behalf of the Authority. The Authority shall, in

its sole discretion, determine the source of funding for such fees, assessments, penalties, or taxes, and shall assume all liability for the appropriateness of use of Health Plan assets or general funds to pay such fees, assessments, penalties and taxes. The Authority understands that Contract Administrator is not an investment advisor, law firm or actuarial firm, and does not render any legal advice to Authority.

SEC. VI **RECORDS**

6.01 The Contract Administrator shall maintain for seven (7) years following receipt or until they are provided to the Authority as provided in Section 8.04 below, in either electronic or paper form, all records and files in conjunction with the administrative services to be performed hereunder. The term "records and files" shall include, but shall not be limited to, the claim files, unissued and canceled checks, bank statements and contracts, and copies of the account ledger sheets of the applicable bank accounts.

6.02 During normal business hours, Contract Administrator will provide to the Authority at Contract Administrator's headquarters access to those records in its immediate custody, relating to Contract Administrator's performance under the Agreement, and not restricted from disclosure under applicable law or agreement between Contract Administrator and a third party. Any such inspection and audit shall occur no more than once every twelve (12) months, and in no greater duration than five (5) consecutive business days, and all reviews hereunder shall be commenced within one year following the period being audited. The Authority shall give Contract Administrator not less than four weeks advanced written notice of its intent to inspect or audit records, with a description of the types of information within the scope of the audit, including dates, a complete listing of transactions and records to be reviewed for the audit and the identity of the proposed auditor's name, title and professional qualifications, as well as a statement concerning the purpose for the audit. The auditor shall be subject to Contract Administrator's approval, which shall not be unreasonably withheld. In the event the Authority and Contract Administrator cannot agree upon an auditor, then one of the top five national accounting firms that offers the lowest price shall be considered a mutually acceptable auditor by both parties. The parties shall agree upon the date for the audit, and audits shall occur in a manner that does not unreasonably interfere with Contract Administrator's ability to conduct its normal business and shall occur at the Authority's sole expense. The Authority shall reimburse Contract Administrator for its cost for an audit that cannot be completed in five business days or that exceeds a sample size greater than twenty-five (25) files and/or transactions (or sixty files and/or transactions if any error is discovered in the sample of 25), or otherwise amounts to exceptional administrative demands. No portion of the audit shall be conducted by an auditor retained on a contingency basis without Contract Administrator's prior written approval. The auditor or inspector shall provide Contract Administrator with copies of all reports and summaries compiled as a result of the audit, including any draft report. The auditors shall meet with Contract Administrator to discuss finding results contained in a draft report. Contract Administrator may at its option include a supplementary statement in any final report. The auditor shall use the information audited solely for purposes of the audit, and shall ensure that the information accessed will be kept confidential in accordance with all applicable laws and professional standards, shall not make photocopies or remove any of the records or information without the express written consent of Contract Administrator. Without waiver of any applicable sovereign immunity under Florida law, the Authority shall indemnify and hold harmless Contract Administrator for any and all claims, costs, expenses and damages that may result from any breaches of the auditor's obligations under this Section.

Once Annually upon written request, the Contract Administrator shall provide a copy of its Type II service auditor report ("SOC Report") to the Authority's independent public accounting firm in connection with the Health Plan's accounting purposes only. The SOC Report is the Contract Administrator's Proprietary Business Information and shall not be shared with any third parties without the Contract Administrator's prior written approval or unless required by applicable law, except that the Authority's independent public accounting firm can share the SOC Report with the Authority's Attorney and independent auditors. Under no circumstances may the Authority's accounting firm, independent public accounting firm or attorney who comes into possession of Contract Administrator's SOC Report (whether in whole or part), share Contract Administrator's SOC Report with persons or entities subject to FLA Stat. § 119.01 et. seq., and the Authority shall ensure that its independent accounting firm, independent auditors and Attorney retain the Report as confidential and that they not disclose such SOC Report to any other persons or entities unless required by applicable law.

6.03 The parties agree to use and disclose the protected health information of the Health Plan Members in a manner consistent with all applicable state and federal laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996, as amended, and the Security Standards and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 and shall execute a Business Associate Agreement.

SEC. VII TERM OF AGREEMENT

7.01 This Agreement shall commence on the Effective Date and shall continue for one (1) year (the "Initial Term"), and thereafter will automatically renew for additional one year terms (each a "Renewal Term"), upon the conclusion of the then current term, unless terminated pursuant to Section VIII of this Agreement.

SEC. VIII TERMINATION

8.01 This Agreement may be terminated:

(a) by either party by giving written notice of non-renewal to the other party at least sixty (60) days prior to the end of the Initial Term or current Renewal Term;

(b) immediately by the non-breaching party in the event the breaching party fails to correct a material breach to the reasonable satisfaction of the non-breaching party within thirty (30) days after the breaching party receives written notification of breach from the non-breaching party;

(c) simultaneously upon the insolvency, filing of a petition for bankruptcy, if such petition is not dismissed within 45 days of being filed , or appointment of a receiver, conservator or trustee for all or substantially all of a party's assets;

(d) upon written agreement of the parties; or

(e) upon the termination of the Health Plan.

8.02 If the Authority terminates the Agreement without providing notice of non-renewal in accordance with Section 8.01(a), it shall compensate Contract Administrator for its reasonable start-up costs associated with this Agreement, which Authority agrees shall be equal to 2 months of Administrative Fees listed on Schedule A.

8.03 This Agreement may be prospectively discontinued by either party upon written correspondence by a governmental authority advising either party that it will be penalized by such governmental authority or jurisdiction, for performance of its responsibilities under this Agreement.

8.04 Upon termination by either party, and for an additional fee, the Contract Administrator shall, within sixty (60) days, deliver to the Authority a paid claims analysis standard report as well as a complete and final accounting of the financial status of the Health Plan if applicable. After the retention period required hereunder, the Contract Administrator shall return or destroy the confidential information or other records of the Health Plan in its possession. Contract Administrator shall retain only those records necessary for its own administrative operations or to respond to an inquiry made by a court, or state or federal agency. If return or destruction of the records is infeasible, Contract Administrator shall extend the protections required by law to such information. If the Authority desires copies of all records and files, the Authority shall allow Contract Administrator reasonable time in which to duplicate this material and will reimburse Contract Administrator for all reasonable costs incurred in its retrieval and duplication.

8.05 Upon termination of this Agreement, and for an additional fee not to exceed 15% higher than the then currently applicable schedule of fees, the Authority and Contract Administrator may enter into a subsequent agreement whereby Contract Administrator will provide run-out claim payment services for claims received after the termination of this Agreement, but incurred prior to termination of this Agreement. The Contract Administrator may require payment in advance, and services will be

provided only to the extent that Authority provides sufficient and timely funding of claims payments.

8.06 After termination of this Agreement and upon receipt of any funds received by the Contract Administrator on behalf of the Authority, the Contract Administrator may keep all or a portion of said funds to the extent that any amounts are due to the Contract Administrator for the services discussed herein.

8.08 Upon termination of this Agreement all duties and responsibilities of the Contract Administrator shall cease unless specifically addressed within this Agreement or as set forth in a separate run-out Agreement.

SEC. IX MISCELLANEOUS

9.01 This Agreement shall be governed by the laws of the State of Florida or, where applicable, Federal law.

9.03 Contract Administrator shall not be responsible or obligated for the investment of any assets or funds of the Health Plan.

9.02 IN NO EVENT SHALL EITHER PARTY BE LIABLE UNDER THIS AGREEMENT FOR ANY SPECIAL, CONSEQUENTIAL, PUNITIVE, INCIDENTAL DAMAGES, OR FOR LOST PROFITS, LOSS OF USE, LOSS OF REPUTATION OR GOODWILL, COST OF PROCUREMENT OF SUBSTITUTE SERVICES OR ANY SIMILAR CLAIM OR DEMAND, AND EACH PARTY EXPRESSLY WAIVES ITS RIGHT TO MAKE ANY CLAIM TO THE CONTRARY. ADDITIONALLY, EXCEPT IN CASES INVOLVING CONTRACT ADMINISTRATOR'S WILLFUL MISCONDUCT, CRIMINAL CONDUCT, FRAUD (AND EXCEPT FOR CONTRACT ADMINISTRATOR'S NEGLIENCE FOR WHICH THE LIMITS ARE SET FORTH BELOW), CONTRACT ADMINISTRATOR'S CUMULATIVE LIABLITY TO THE AUTHORITY WILL NOT EXCEED THE ADMINISTRATIVE FEES ACTUALLY PAID BY THE AUTHORITY, TO CONTRACT ADMINISTRATOR FOR THE TWELVE-MONTH PERIOD PRIOR TO THE ACT OR OMISSION GIVING RISE TO ANY SUCH LIABILITY OR OBLIGATION. IN THE CASE OF CONTRACT ADMINISTRATOR'S NEGLIENCE, CONTRACT ADMINISTRATOR'S CUMULTIVE LIABILITY TO THE AUTHORITY WILL NOT EXCEED $2 MILLION DOLLARS. EACH PROVISION OF THIS AGREEMENT THAT PROVIDES FOR A LIMITATION OF LIABLITY OR EXCLUSION OF DAMAGES IS INTENDED TO ALLOCATE RISK OF THIS AGREEMENT BETWEEN THE PARTIES. THIS ALLOCATION IS REFLECTED IN THE PRICING OFFERED BY CONTRACT ADMINSTRATOR TO THE AUTHORITY AND IS AN ESSENTIAL ELEMENT OF THE BASIS FOR THE BARGAIN BETWEEN THE PARTIES.

9.03 Payments to the Health Plan, and other Health Plan obligations, may pass through Contract Administrator's "Account" and/or other non-interest bearing disbursement account(s) as a matter of convenience and for efficiency. Contract Administrator will incorporate sound business practices and be responsible for reasonable internal audits. Banking charges incurred in the ordinary course of business will be the responsibility of the Contract Administrator.

9.05 This Agreement, together with the Schedule(s) and any Amendments, constitutes the entire Agreement between Contract Administrator and Authority with respect to the subject matter hereof, and supersedes all prior proposals, discussions, negotiations, and writings between the parties relating to such subject matter. This Agreement may only be modified in writing and executed by authorized representatives of both Contract Administrator and the Authority.

9.06 If any provision of this Agreement is held to be illegal or unenforceable by a court of competent jurisdiction, the remaining provisions shall remain in effect and the illegal or unenforceable provision shall be modified so as to conform to the original intent of this Agreement to the greatest extent legally permissible.

9.07 The obligations of either Contract Administrator or Authority under this Agreement, shall be suspended during the continuance of any force majeure applicable to the party. The term "force majeure" shall mean any cause not reasonably within the control of the party claiming suspension, including, without limitation, an act of God, industrial disturbance, war, riot, weather-related

disasters, earthquake, governmental action, and unavailability or break down of equipment. The party claiming suspension under this provision shall take reasonable steps to resume performance as soon as possible without incurring unreasonably excessive costs. If a force majeure suspension affecting one of the parties continues for more than thirty (30) days, the other party may elect to immediately terminate this Agreement by written notice on any business day thereafter.

9.08 Neither party may assign its rights or duties under this Agreement without the prior written consent of the other. This Agreement and/or any of its duties arising thereunder may be performed by sub-contractors. This Agreement shall be binding upon and inure to the benefit of the parties' respective successors and permitted assigns.

9.09 Any failure by a party to enforce or require performance by the other party of any of the terms or conditions of this Agreement shall not constitute a waiver or a breach of any such term or condition thereafter occurring.

9.10 Contract Administrator, at its sole cost and expense, shall during the term of this Agreement keep and maintain TPA Professional Liability insurance as well as Managed Care E&O insurance covering its activities under this Agreement and with policy limits of not less than $2 million dollars. Contract Administrator additionally agrees to keep and maintain those other policies of insurance as may be customary for other similarly situated claims administrators within the same industry.

SEC. X DISPUTE RESOLUTION

11.01 Any controversy or claim arising out of or relating to this Agreement, including by way of example only, the breach, termination, validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be subject to informal dispute resolution, whereby the parties hereto shall meet and confer in good faith to resolve any disputes arising during the term of the Agreement. If the parties are unable to resolve a dispute through such discussions, the party brining the complaint shall propose in writing a reasonable manner of resolving the dispute. The other party shall respond by accepting, rejecting or modifying the proposal, in writing within thirty (30) days of the date it receives the proposed resolution. Discussions, negotiations and documents shared throughout the informal dispute resolution period shall be treated as inadmissible, compromise and settlement negotiations held for purposes of applicable rules of evidence. In the event the parties are unable to resolve the dispute within sixty (60) days through such informal dispute resolution, and either party wishes to pursue the dispute further, that party will refer the dispute to non-binding mediation under the Commercial Mediation Rules of the American Arbitration Association ("AAA"). In no event may the mediation be initiated more than one year after the date one party first gave written notification of the dispute to the other party. A single mediator engaged in the practice of law, who is knowledgeable about benefit plan administration, will conduct the mediation under the then current rules of the AAA. The mediation will be held in a mutually agreeable site. Nothing in this Section is intended to prevent either party from seeking any other remedy available at law including seeking redress in a court of competent jurisdiction. The parties hereby agree that if the Contract Administrator is a defendant in any such court action, the Contract Administrator shall be deemed to reside within the Middle District of Florida and venue shall be proper in that federal district's Tampa, Florida location based on the Contract Administrator's in personam jurisdiction there. This provision shall survive the termination of this Agreement.

SEC. XII SCHEDULES TO THE AGREEMENT

12.01 The Schedules attached hereto, become part of the body of this Agreement, and are herein incorporated by reference when selected by the Authority. Schedules or Amendments subsequently executed by both parties and attached hereto, shall become part of the body of this Agreement and incorporated herein.

IN WITNESS THEREOF the Parties hereto sign their names as duly authorized officers and have executed this Agreement.

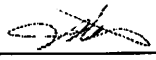
AUTHORITY:

By: _____

Its: _____

CONTRACT ADMINISTRATOR:

Employee Benefit Management Services, LLC

By: 

Its: President

SCHEDULE A

FEES

A. In accordance with Section III of the Administrative Services Agreement, the Authority agrees to pay to the Contract Administrator the following Administrative Fees:

Benefit Management Global Fee	$21.50 per member per month (measured on the 1st day of each month)

A portion of the Benefit Management Global Fee is designated for and forwarded to Contract Administrator's vendor partner(s) for the provision of certain services elected by Authority.

B. Authority shall pay Contract Administrator its then current fee for assistance in the Health Plan's preparation of Documents.

Additionally, Authority shall pay Contract Administrator its then current fee for preparation of related Health Plan documents and benefit summaries if new legislation or regulatory changes require Contract Administrator to assist Health Plan in its modification of related Documents to comply with the new requirements.

C. Authority authorizes Contract Administrator to deduct the administrative fees for each month from proceeds transferred by the Authority into the Account. The Contract Administrator shall also be authorized to deduct any applicable taxes, fees, assessments and or penalties from proceeds transferred by the Authority into the Account upon prior notice to the Authority.

D. An initial contract set-up fee of $__N/A___ representing the first month's estimated fees shall be payable by Authority on or before the effective date of this Agreement.

E. An initial one-time set-up fee of $__N/A___ for eligibility loading, Health Plan building and other services, shall be payable prior to commencement of services under this agreement.

F. Additional Administrative Fees may be reflected on the applicable Schedule.

G. The fee and rates outlined in Schedule A shall be renewed and revised as necessary, but in no event less than annually to be mutually acceptable to both parties.

H. In the event that legislative or regulatory changes ("Changes in Law") significantly increase the costs for Contract Administrator to perform its duties and obligations under this Agreement for Authority, Contract Administrator and Authority shall work together to negotiate a change in the Benefit Management Global Fee that seeks to preserve the relative economics between the parties prior to such change. Such negotiations shall be completed within ninety (90) days of the effective date of the Change in Law. If Contract Administrator and Authority cannot agree to a mutually acceptable modification of the Benefit Management Global Fee within such ninety (90) day period, then either party may terminate this Agreement upon ninety (90) days' written notice after such period.

Effective Date: January 1, 2020

West Volusia Healthcare Authority:

By: _____

Its: _____

CONTRACT ADMINISTRATOR:

Employee Benefit Management Services, LLC

By: _____

Its: President

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountant | Registered Investment Advisor
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Melissa J. Trickey, CPA

November 5, 2019

West Volusia Hospital Authority
Board of Commissioners
PO Box 940
DeLand, FL 32720

Re: Northeast Florida Health Services dba Family Health Source (FHS) Primary Care/OB/GYN/Pharmacy Site Visit Write Up 2019

Dear Commissioners:

We have performed the procedures detailed in our engagement letter for grantee site visits, dated July 18, 2019 which were agreed to by West Volusia Hospital Authority (WVHA) Board of Commissioners, solely to assist you with respect to funding agreement compliance of Northeast Florida Health Services dba Family Health Source (FHS) Primary Care Services, Obstetrics/Gynecology (OB/GYN) and Pharmacy Services for the year ending September 30, 2019. WVHA reimburses FHS for primary care visits provided to West Volusia County residents. The engagement to apply the agreed upon procedures was performed in accordance with the standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those parties specified in the report. Consequently, we make no representation regarding the sufficiency of the procedures described below, either for the purpose for which this report has been requested or for any other purpose.

Our procedures and findings are below:

1. Inquire and document as to the grantee's monitoring procedures with respect to contract compliance.

    a. FHS provides to UMR, the WVHA third party administrator, electronic claims submissions detailing clients served who qualify for WVHA funding.
    b. FHS – HealthCard eligibility is verified through UMR's electronic portal and through presentation of the WVHA HealthCard and photo identification.

2. Select a sample of transactions and test compliance with contract provisions.

    a. January 2019 through March 2019 was chosen for test procedures. A non-summarized list of client visits was provided by UMR (6,400 visits).
    b. From the list of client visits, forty-five (45) primary care (PCP) and OB/GYN visits were selected for compliance review. Of those forty-five (45) visits, thirty-five (35) were PCP visits and ten (10) were OB/GYN visits. All files were unique patients except for OB/GYN services; one client incurred two (2) visits and one client incurred three (3). One hundred percent (100%) of all visits were confirmed.
    c. From the list of clients served, forty-five (45) PCP & OB/GYN visits selected for compliance review, one hundred percent (100%), were determined to be compliant with an active WVHA HealthCard and photo ID.
    d. From the list of forty-five (45) clients served, twenty-one (21) clients received prescriptions that were written and issued for ninety (90) day supplies when appropriate, or one hundred percent (100%).

3. Prepare a written report summarizing the results with recommendations to the Board of Commissioners.

Primary visit information should continue to be transmitted to the Third Party Administrator to eliminate duplication, ensure eligibility at the time of visit, maintain the quality of the medical information kept on eligible patients and assist the WVHA Board of Commissioners in quantifying individual patients served and dollars spent per patient. This has proven to be an effective and efficient process.

We were not engaged to, and did not, conduct an audit, the objective of which would be the expression of an opinion, on the specified elements, accounts, or items. Accordingly, we do not express such an opinion. Had we performed additional procedures; other matters might have come to our attention that would have been reported to you.

This report is intended solely for the information and use of the specified users listed above and is not intended to be and should not be used by anyone other than those specified parties.

Dreggors, Rigsby & Teal, P.A.

WEST VOLUSIA HOSPITAL AUTHORITY

DeLand City Hall
120 S. Florida Avenue, DeLand, FL

TENTATIVELY SCHEDULED MEETINGS - 2020

Citizens Advisory Committee Meetings Tuesdays at 5:15pm	Joint Meetings	Board of Commissioners Meetings Thursdays at 5:00pm
		January 16 - Organizational/Regular
February 4 - CAC Organizational/Orientation *Judy Craig		February 20 (ADVENT HOSP/HSCFV)
March 3 – Applicant Workshop *Andy Ferrari		March 19 (TNC/FDOH) (TPA to Attend)
April 16 – 5 p.m. Joint meeting of WVHA Board and CAC – Preliminary Funding Application Review		
May 5 - Discussion/Q&A Meeting *John Hill		May 21 (ADVENT HOSP-SMA/RAAO)
May 26 - Ranking Meeting * Dolores Guzman		
June 18 – 4 p.m. Primary Care Application Workshop (duration 1 ½ hours)		
June 18 – 5:30 p.m. Joint meeting of WVHA Board and CAC–Funding Recommendations		
July (CAC Hiatus)		July16 (4:00 p.m.) Budget Workshop Followed by Regular (THND/Healthy Comm) (TPA to Attend)
August (CAC Hiatus)		August 20 (ADVENT HOSP/HHI/CLSMF)
		September 10 – Initial Budget Hearing
September (CAC Hiatus)		
		September 24 - Final Budget Hearing/Regular Meeting
October (CAC Hiatus)		October 15
November (CAC Hiatus)		November 19 (ADVENT HOSP)

*WVHA Commissioner to attend CAC Meeting
Meetings to be held at DeLand City Hall Commission Chamber 120 S. Florida Avenue, DeLand FL
Meetings to be held at DRT, 1006 N. Woodland Blvd., DeLand, FL
Meeting to be held at DeLand Police Department Community Room 219 W. Howry Ave, DeLand, FL

Tenatative schedule for bi- monthly accounts payables

SCHEDULE FOR 2020

MONTH	COMMISSIONERS
JANUARY	
THURS 1/9	FERRARI/HILL
Board Meeting 1/16/2020	
THURS 1/30	HILL/GUZMAN
FEBRUARY	
THURS 2/13	GUZMAN/MANNING
Board meeting 2/20/2020	
MARCH	
THURS 3/5	MANNING/FERRARI
Board Meeting 3/19/2020	
APRIL	
THURS 4/2	FERRARI/HILL
Board Meeting 4/16/2020	
THURS 4/30	HILL/GUZMAN
MAY	
THURS 5/14	GUZMAN/MANNING
Board Meeting 5/21/2020	
JUNE	
THURS 6/4	MANNING/FERRARI
Board Meeting 6/18/2020	
JULY	
JULY 4TH HOLIDAY SCHEDULING	
THURS 7/9	FERRARI/HILL
Board Meeting 7/16/2020	
THURS 7/30	HILL/GUZMAN

MONTH	COMMISSIONERS
AUGUST	
THURS 8/13	GUZMAN/MANNING
Board Meeting 8/20/2020	
SEPTEMBER	
THURS 9/10	MANNING/FERRARI
THURS 9/24	FERRARI/HILL
OCTOBER	
THURS 10/8	HILL/GUZMAN
Board Meeting 10/15/2020	
THURS 10/29	GUZMAN/MANNING
NOVEMBER	
THURS 11/12	MANNING/FERRARI
Board Meeting 11/19/2020	
THANKSGIVING	
DECEMBER	
THURS 12/3	FERRARI/HILL
THURS 12/10	HILL/GUZMAN
THURS 12/30	GUZMAN/MANNING
NO PAYABLES UNTIL THURSDAY 1/7/2021	
2020	
JANUARY	
THURS 1/7	MANNING/FERRARI
Board Meeting 1/21/2021	

FOURTEENTH ADDENDUM

This Fourteenth Addendum is entered into by and between MEMORIAL HOSPITAL-WEST VOLUSIA, INC. d/b/a ADVENTHEALTH DELAND, a Florida not for profit corporation ("FHD"), SOUTHWEST VOLUSIA HEALTHCARE CORPORATION d/b/a ADVENTHEALTH FISH MEMORIAL, a Florida not for profit corporation ("Southwest Volusia"), and WEST VOLUSIA HOSPITAL AUTHORITY, a special taxing district, public body corporate and politic of the State of Florida in Volusia County, Florida (the "Authority"), effective October 1, 2019.

Whereas, FHD, Southwest Volusia and the Authority entered into the Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement in October of 2005, for reimbursement to FHD and Southwest Volusia for Physician Services rendered to Charity Care Patients through September 30, 2006 ("Reimbursement Agreement" or "Agreement"); and

Whereas, FHD, Southwest Volusia and the Authority entered into Addendums to the above referenced Reimbursement Agreement for reimbursement through September 30, 2019; and

Whereas, FHD, Southwest Volusia and the Authority desire to continue with the Program under the Agreement through September 30, 2020.

NOW THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. The Authority shall continue with the reimbursement to FHD and Southwest Volusia (Collectively "Hospitals") for Qualified Physician Services, during the period from October 1, 2019 through September 30, 2020.

2. The Reimbursement Period under the Agreement shall include the additional period from October 1, 2019 through September 30, 2020.

3. The Reimbursement Rate under the Agreement shall remain the same, for the period from October 1, 2019 through September 30, 2020, as follows:
   (i) For inpatient care, a flat fee of $315.79 per admission; and
   (ii) For Emergency Department care, a flat fee of $68.42 per patient visit.
   The parties agree to review these rates in the event legislation or regulations are adopted, which materially affect the Medicare Physician Fee Schedule.

4. The Annual Payment Cap of $225,000.00 (Two Hundred Twenty-Five Thousand Dollars) under the Agreement shall apply, for the combined reimbursement to the Hospitals by the Authority for Qualified Physician Services rendered by the Hospitals during the period from October 1, 2019 through September 30, 2020; provided however, the Hospitals hereby agree to pay physicians salaried or contracted by the Hospitals up to $50,000.00 of the Annual Payment Cap and to utilize the remaining $175,000.00 of the Annual

Payment Cap to reimburse physicians that are salaried or contracted by its emergency physicians subcontractor (currently Emergency Medicine Professionals, P.A. ("EMPros") for treating qualified Charity Care Patients in the emergency departments of the Hospitals. If by the deadline for submission of invoices for the Reimbursement Period either the Hospitals physicians or EMPros physicians have not exhausted their allocated portion of the Annual Payment Cap, the parties agree that the Hospitals may utilize the unexhausted amount to reimburse unpaid, but timely submitted invoices from the alternative group of physicians.

5. Any term not defined herein shall have the same meaning as under the Agreement.
6. The provisions of the Agreement shall continue to control the relationship of the parties, except as specifically modified by the content of this Addendum.

IN WITNESS THEREOF, the parties have executed this Addendum as of the day and year set forth below.

Two Witnesses:

_____

_____
Print Name

_____

_____
Print Name

ATTEST:
By:_____
Name: Andrew N. Ferrari
Title: Secretary

WEST VOLUSIA HOSPITAL AUTHORITY,
a special taxing district, public body corporate and politic of the State of Florida

By:_____
Name: Judith L. Craig
Title: Chair
Date:_____

Two Witnesses:

Cindy L. Martin

Cindy L. Martin
Print Name

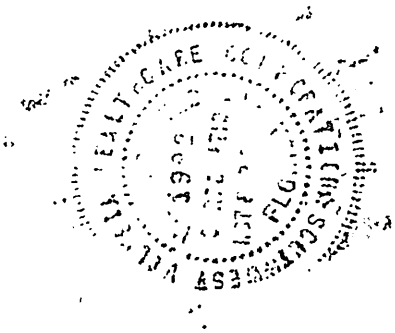
SOUTHWEST VOLUSIA HEALTHCARE CORPORATION d/b/a ADVENTHEALTH FISH MEMORIAL,
a Florida not for profit corporation

By: Eric Ostarly
Name: Eric Ostarly
Title: Chief Financial Officer
Date: 10-11-19

Luis A Rodriguez
Print Name

ATTEST:
By:_____
Name:_____
Title:_____

(Corporate Seal)



Two Witnesses:

Claire Sweeney
Claire Sweeney
Print Name

Sonia A Guyer
Sonia A Guyer
Print Name

ATTEST:
By:_____
Name:_____
Title:_____

MEMORIAL HOSPITAL-WEST VOLUSIA, INC. d/b/a ADVENTHEALTH DELAND,
a Florida not for profit corporation

By:_____
Name: Kyle Glass
Title: Chief Financial Officer
Date: 10/11/19

(Corporate Seal)

West Volusia Hospital Authority
Financial Statements
October 31, 2019

Dreggors, Rigsby & Teal, P.A.
Advisors for Life
Certified Public Accountant | Registered Investment Advisor
1006 N. Woodland Boulevard ■ DeLand, FL 32720
(386) 734-9441 www.drtcpa.com

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Ann J. Rigsby, CPA/PFS/CFP®
Melissa J. Trickey, CPA

To the Board of Commissioners
West Volusia Hospital Authority
P. O. Box 940
DeLand, FL 32720-0940

Management is responsible for the accompanying balance sheet (modified cash basis) of West Volusia Hospital Authority, as of October 31, 2019 and the related statement of revenues and expenditures - budget and actual (modified cash basis) for the month then ended and year-to-date, in accordance with accounting principles generally accepted in the United States of America. We have performed a compilation engagement in accordance with Statements on Standards for Accounting and Review Services promulgated by the Accounting and Review Services Committee of the AICPA. We did not audit or review the financial statements nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on these financial statements.

The accompanying supplemental information contained in Schedules I and II is presented for purposes of additional analysis and is not a required part of the basic financial statements. This information is the representation of management. The information was subject to our compilation engagement; however, we have not audited or reviewed the supplementary information and, accordingly, do not express an opinion, a conclusion, nor provide any assurance on such supplementary information.

Management has elected to omit substantially all of the disclosures required by accounting principles generally accepted in the United States of America. If the omitted disclosures were included in the financial statements, they might influence the user's conclusions about the Authority's financial position, results of operations, and cash flows. Accordingly, the financial statements are not designed for those who are not informed about such matters.

We are not independent with respect to West Volusia Hospital Authority.

Dreggors, Rigsby & Teal, P.A.

Dreggors, Rigsby & Teal, P.A.
Certified Public Accountants
DeLand, FL

November 05, 2019

West Volusia Hospital Authority
Balance Sheet
Modified Cash Basis
October 31, 2019

Assets

Current Assets		
Petty Cash	$	100.00
Intracoastal Bank - Money Market		7,847,996.07
Intracoastal Bank - Operating		500,030.52
Mainstreet Community Bank - MM		5,041,725.71
Taxes Receivable		92,073.00
Total Current Assets		**13,481,925.30**
Fixed Assets		
Land		145,000.00
Buildings		422,024.71
Building Improvements		350,822.58
Equipment		251.78
Total Fixed Assets		**918,099.07**
Less Accum. Depreciation		(296,440.64)
Total Net Fixed Assets		**621,658.43**
Other Assets		
Deposits		2,000.00
Total Other Assets		**2,000.00**
Total Assets		**14,105,583.73**

Liabilities and Net Assets

Current Liabilities		
Security Deposit		5,110.00
Deferred Revenue		88,660.00
Total Current Liabilities		**93,770.00**
Net Assets		
Unassigned Fund Balance		14,632,865.03
Restricted Fund Balance		208,000.00
Nonspendable Fund Balance		621,658.43
Net Income Excess (Deficit)		(1,450,709.73)
Total Net Assets		**14,011,813.73**
Total Liabilities and Net Assets	$	**14,105,583.73**

West Volusia Hospital Authority
Statement of Revenue and Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 1 Month Ended October 31, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Revenue				
Ad Valorem Taxes	19,350,000	20,278	20,278	19,329,722
Investment Income	135,000	9,939	9,939	125,061
Rental Income	71,988	5,999	5,999	65,989
Total Revenue	**19,556,988**	**36,216**	**36,216**	**19,520,772**
Healthcare Expenditures				
Adventist Health Systems	5,904,295	0	0	5,904,295
Northeast Florida Health Services	2,187,941	157,317	157,317	2,030,624
Specialty Care	3,500,000	362,049	362,049	3,137,951
County Medicaid Reimbursement	2,452,561	817,520	817,520	1,635,041
The House Next Door	110,000	8,619	8,619	101,381
The Neighborhood Center	150,000	0	0	150,000
Rising Against All Odds	219,000	24,150	24,150	194,850
Community Legal Services	86,627	0	0	86,627
Hispanic Health Initiatives	75,000	1,625	1,625	73,375
Florida Dept of Health Dental Svcs	228,000	848	848	227,152
Stewart Marchman - ACT	976,000	(753)	(753)	976,753
Health Start Coalition of Flagler & Volusia	142,359	5,937	5,937	136,422
H C R A	819,162	0	0	819,162
Other Healthcare Costs	303,780	0	0	303,780
Total Healthcare Expenditures	**17,154,725**	**1,377,312**	**1,377,312**	**15,777,413**
Other Expenditures				
Advertising	6,800	165	165	6,635
Annual Independent Audit	16,400	0	0	16,400
Building & Office Costs	6,500	175	175	6,325
General Accounting	68,100	4,948	4,948	63,152
General Administrative	65,100	4,675	4,675	60,425
Legal Counsel	70,000	5,740	5,740	64,260
Special Accounting	5,000	0	0	5,000
City of DeLand Tax Increment District	100,000	0	0	100,000
Tax Collector & Appraiser Fee	650,000	50	50	649,950
Legislative Consulting	60,000	5,000	5,000	55,000
TPA Services	663,938	38,855	38,855	625,083
Healthy Communities	74,363	6,259	6,259	68,104
Application Screening				
Application Screening - THND	391,062	30,510	30,510	360,552
Application Screening - RAAO	50,000	4,608	4,608	45,392
Workers Compensation Claims	25,000	8,459	8,459	16,541
Other Operating Expenditures	150,000	170	170	149,830
Total Other Expenditures	**2,402,263**	**109,614**	**109,614**	**2,292,649**
Total Expenditures	19,556,988	1,486,926	1,486,926	18,070,062
Excess (Deficit)	**0**	**(1,450,710)**	**(1,450,710)**	**1,450,710**

See Accountants' Compilation Report

West Volusia Hospital Authority
Schedule I - Healthcare Expenditures
Modified Cash Basis
Budget and Actual
For the 1 Month and 1 Month Ended October 31, 2019

	Annual Budget	Current Period Actual	Year To Date Actual	Budget Balance
Healthcare Expenditures				
Adventist Health Systems				
Florida Hospital DeLand	2,839,647	0	0	2,839,647
Florida Hospital Fish Memorial	2,839,648	0	0	2,839,648
Florida Hospital DeLand - Physicians	112,500	0	0	112,500
Florida Hospital Fish - Physicians	112,500	0	0	112,500
Northeast Florida Health Services				
NEFHS - Pharmacy	1,000,320	53,681	53,681	946,639
NEFHS - Obstetrics	0	3,854	3,854	(3,854)
NEFHS - Primary Care	1,187,621	99,782	99,782	1,087,839
Specialty Care	3,500,000	362,049	362,049	3,137,951
County Medicaid Reimbursement	2,452,561	817,520	817,520	1,635,041
Florida Dept of Health Dental Svcs	228,000	848	848	227,152
Good Samaritan				
The House Next Door	110,000	8,619	8,619	101,381
The Neighborhood Center	100,000	0	0	100,000
TNC Healthcare Navigation Program	50,000	0	0	50,000
Rising Against All Odds	219,000	24,150	24,150	194,850
Community Legal Services	86,627	0	0	86,627
Hispanic Health Initiatives	75,000	1,625	1,625	73,375
Stewart Marchman - ACT				
SMA - Homeless Program	126,000	0	0	126,000
SMA - Residential Treatment	550,000	(753)	(753)	550,753
SMA - Baker Act - Match	300,000	0	0	300,000
Health Start Coalition of Flagler & Volusia				
HSCFV - Outreach	73,500	5,937	5,937	67,563
HSCFV - Fam Services	68,859	0	0	68,859
HCRA				
H C R A - In County	400,000	0	0	400,000
H C R A - Outside County	419,162	0	0	419,162
Other Healthcare Costs	303,780	0	0	303,780
Total Healthcare Expenditures	**17,154,725**	**1,377,312**	**1,377,312**	**15,777,413**

West Volusia Hospital Authority
Schedule II - Statement of Revenue and Expenditures
Modified Cash Basis
For the 1 Month and 1 Month Ended October 31, 2019 and October 31, 2018

	1 Month Ended October 31, 2019	1 Month Ended October 31, 2018	1 MonthEnded October 31, 2019	1 Month Ended October 31, 2018
Revenue				
Ad Valorem Taxes	20,278	6,495	20,278	6,495
Investment Income	9,939	6,489	9,939	6,489
Rental Income	5,999	5,692	5,999	5,692
Total Revenue	36,216	18,676	36,216	18,676
Healthcare Expenditures				
Adventist Health Systems	0	55,825	0	55,825
Northeast Florida Health Services	157,317	11,294	157,317	11,294
Specialty Care	362,049	82,898	362,049	82,898
County Medicaid Reimbursement	817,520	195,966	817,520	195,966
The House Next Door	8,619	0	8,619	0
Rising Against All Odds	24,150	0	24,150	0
Hispanic Health Initiatives	1,625	0	1,625	0
Florida Dept of Health Dental Svcs	848	0	848	0
Stewart Marchman - ACT	(753)	0	(753)	0
Health Start Coalition of Flagler & Volusia	5,937	0	5,937	0
Total Healthcare Expenditures	1,377,312	345,983	1,377,312	345,983
Other Expenditures				
Advertising	165	2,210	165	2,210
Building & Office Costs	175	316	175	316
General Accounting	4,948	0	4,948	0
General Administrative	4,675	0	4,675	0
Legal Counsel	5,740	1,240	5,740	1,240
Tax Collector & Appraiser Fee	50	118	50	118
Legislative Consulting	5,000	0	5,000	0
TPA Services	38,855	27,250	38,855	27,250
Healthy Communities	6,259	0	6,259	0
Application Screening				
Application Screening - THND	30,510	0	30,510	0
Application Screening - RAAO	4,608	0	4,608	0
Application Screening - SMA	0	0	0	0
Workers Compensation Claims	8,459	0	8,459	0
Other Operating Expenditures	170	213	170	213
Total Other Expenditures	109,614	31,347	109,614	31,347
Total Expenditures	1,486,926	377,330	1,486,926	377,330
Excess (Deficit)	(1,450,710)	(358,654)	(1,450,710)	(358,654)

LEGAL UPDATE MEMORANDUM

TO: WVHA Board of Commissioners

DATE: November 5, 2019

FROM: Theodore W. Small, Jr.

RE: West Volusia Hospital Authority - Update for November 14, 2019 Regular Meeting

Summarized below are updates on active legal matters/issues for which some new information has become available since my last legal update. This Memorandum will not reflect updates on matters resolved by a final vote of the Board and thereby already summarized in the October 17, 2019 Meeting Minutes.

I. Negotiations with EBMS on new TPA Administrative Services Agreement.

As instructed during the October 2019 Regular Meeting, counsel negotiated and reached agreement with EBMS's counsel on the terms of a potential new administrative services agreement with EBMS. Accordingly, on October 30th priority mailed and emailed UMR a 60-day notice of termination (effective 1/1/2020) pursuant to Section 9.2(3) of the Administrative Services Agreement between UMR, Inc and WVHA. UMR Strategic Account Executive, Donna Lupo acknowledged receipt of notice of termination on October 31st and counsel spoke with Ms. Lupo on November 1st to explain only that the Board had decided to move in a different direction. In response to her request for particulars, counsel suggested that she wait until after the November Board meeting when the new TPA contract would be considered and when the Board might be willing to authorize an "exit interview" with Ms. Long to provide Ms. Lupo with some particulars about DRT's interactions with UMR staff.

Regarding the new agreement, previously counsel circulated to the Board (via 10/25/19 email) a redlined draft to summarize EBMS's initially proposed contract, counsel's counterproposals and a compromise concerning Section 9.02 which limits EBMS's liability for negligence to $2 million dollars. Subsequently, we reached agreement on the final draft of the new Administrative Services Agreement with EBMS after substantially negotiating further modifications to Sections 1.08 (confidentiality vs. public records); Section 2.01(l) (EBMS maintenance of claims payment bank account); Section 6.02 (auditing process); Section 11.01 (non-binding mediation and venue for litigation of disputes), as well as other clarifications.

Based on those changes and after consulting with DRT to confirm its agreement on accounting points, counsel recommends to the Board for approval as to legal form the Administrative Services Agreement drafted 10/30/19#2 , which will be circulated via mail and included hard copy in your Board Meeting Materials.

II. Discussions with EMPros Re: Restructuring Nature of Primary Care Physicians

Indigent Hospital Patient Program Reimbursement Agreement (2005), as amended. [*See new info. in italics and bold*] *[Refer back to Legal Update Memorandum dated 3/21/19 and June 11, 2019 for additional background details.]*

As proposed during the November 2018 Regular Meeting, Ms. Maureen France organized a joint meeting on December 11, 2018 at Florida Hospital DeLand with herself, EMPros President, Charles D. Duva, MD, EMPros Regional Operations Coordinator, Kristin McCabe-Kline, MD, FHD CFO, Kyle Glass (FHFM CFO, Eric Ostarly was expected but unable to attend). The discussion lasted about one and a half hours and focused principally on sharing background on 1. how the underlying 2006 Agreement which is subject to renewal each year, is a separate and distinct agreement from the 2000 Omnibus Agreement concerning the sale of the Hospital to Adventist, which is a 20 year agreement that is set to expire in September, 2020; 2. Why the 2005 Agreement was structured between WVHA and the Hospitals in 2005 without EMPros as a party; 3. how EMPros contracted with the Hospitals year after year without even becoming aware that the pool of monies it was being paid for providing physicians to staff the Hospitals' ERs was based on funding received from WVHA; 4. how the recent changes in federal and state programs that otherwise reimburse EMPros services and also the approximate 10% increases in qualified Health Card patients, is now motivating EMPros to seek more reimbursements to avoid a reduction in the quality of services available to all ER patients; 5. why EMPros would prefer to negotiate a reimbursement contract directly with WVHA as opposed to having the Hospitals as intermediaries for whatever reimbursements are provided by WVHA, and how it would be willing to propose multiple options for a restructured agreement including being contracted as specialists in the UMR network, negotiating a higher per patient amount which is adjusted for inflation from the amount agreed to in the 2005 Agreement, or a flat rate overall annual reimbursement amount to make the overall funding predictable to WVHA and cut down on paperwork on both sides; 6. why the Hospitals would prefer not to remain as intermediaries and may be willing to ask for less monies to reimburse the Hospitals for the separate category of inpatient physician services which is currently covered under the same 2005 Agreement and often leads to depletion of reimbursements that are available to EMPros before the WVHA funding year. Counsel emphasized to those gathered that the option of including EMPros as specialists is impractical on a number of levels, including the fact that specialty care network is managed, contracted and owned by UMR, not WVHA and restructuring finally settled WVHA policies that establish a PCP referral for all specialty services reimbursed under that network. The meeting concluded with EMPros taking on responsibility for coming up with a proposal that clearly and specifically explains what it wants to be paid and why those amounts are justified based on comparisons with the overall marketplace.

During its presentation at the March meeting, EMPros committed to putting its proposal for a direct contract with WVHA in a completed funding application. To date counsel has not been provided with a copy of EMPros's completed application. Depending on its contents as to rates of reimbursement and proposed funding limit, the Board will need to consider whether this application should be reviewed alongside other non-primary care applications that are usually processed by the CAC in the first instance, or whether it should be reviewed directly by the Board without a preliminary review by the CAC. Regardless of how this application is processed, the Board (and if applicable, the CAC) should be mindful that a decision to fund

EMPros directly is akin to past decisions where prior Boards have been persuaded to take on financial responsibility to pay for health care costs that are the actual responsibility of other entities with greater resources (e.g., HCRA, Medicaid Match, Baker Act, which are all programs which would fall upon the County of Volusia if WVHA had refused or ever refuses to pay, or ceases to exist/is statutorily eliminated and is therefore unable to pay). In this instance, the federal government places responsibility for providing quality ER services on the current owner and operator of the hospitals, Adventist Health Systems. WVHA will need to be mindful of its fiduciary obligation to taxpayers as it evaluates the degree to which it will undertake more financial responsibility from Adventist Health Systems to fairly compensate the ER specialists, which Adventist Health Systems is required to do as a cost of owning and operating the hospitals. In this regard, please recall that as of October 1, 2020, unless a renewal contract is negotiated, Adventist Health Systems will own and operate the hospitals without any restrictions or control, or requirement of reimbursement for ER services by WVHA. In view of the CAC's decision to pass back to the Board responsibility for determining whether or not to fund EMPros directly for the healthcare it provides to Healthcard members in Adventist Health's ER, counsel reiterates the above background overview to assist the Board in framing its decision.

As requested, counsel forwarded to Board members electronic copies of the "Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement" (2005), which establishes a funding limit and rate of reimbursement to physicians per inpatient hospital stay and ER visits, and its most recent "13th Addendum to Primary Care Physicians Indigent Hospital Patient Program Reimbursement Agreement" (2018). As discussed during the last meeting, the total funding limit was reduced from $325,000 to $225,000 but nothing else has changed about the reimbursement rate or other terms of the original 2005 agreement. It has been a year-to-year agreement which has been renewed every year without any other substantive requests for modification from either party. In considering EmPros' pending funding application and the various proposals for reducing the existing budget line item for payments to the hospitals and for creating a separate line item to fund EmPros under a completely new and separate funding agreement for the 2019-2020 funding cycle, the following background and considerations are worth noting:

1. EmPros as a subcontractor of the hospitals was NOT a party to this 2005 agreement or any of its renewals. Instead, EmPros has been contracting directly with the hospitals for whatever reimbursements it has received over the years. As discussed during the last meeting, WVHA has no legal basis for supervising the contractual relationships that the hospitals establish with EmPros or any of other subcontractors or employees of the hospitals, except as they would directly impact the hospitals fulfilling their commitment to maintain quantify and quality of services as agreed in WVHA's own agreements with the hospitals.
2. Although it is understandable that EmPros would desire to discontinue what arguably has been a low pay or no pay deal it has been willing to accept all these years, and it is also understandable that the hospitals would rather shift some of its federal law responsibility for providing quality ER services to WVHA, counsel does NOT recommend this type of fundamental restructuring of contractual relationships for this 2019-20 funding year.
3. Any such restructuring should be postponed until the 2020-21 and beyond funding

cycle(s) as a part of the overall set of decisions that the Board will need to make regarding how best to commit tax revenues to maintain and enhance hospital services for indigent residents. The Board should take care to avoid shifting to itself duties and responsibilities that federal and state law imposes on the owners and operators of hospitals, which is the role that Adventist took on for itself effective October 1, 2000.

4. To the extent that a majority of the Board is inclined to do any restructuring at all for this current funding cycle, counsel recommends that the upcoming 14th Addendum to the 2005 provision be revised to specify that no less than $175K of the total funding limit be made available to reimburse EMPros, which is the amount that the hospitals have confirmed they are willing to shift to EmPros out of the current $225K funding limit. Additionally, counsel recommends that the Board give consideration to adjusting the rate of reimbursement based on whatever EmPros submits to demonstrate that it has not contracted to charge a lower rate for similar services at similarly situated hospitals, as well as a potential adjustment in the total funding limit to fund that adjusted rate for what is determined to be a valid projected number of ER visits in the coming year based on the Board's determination at the last meeting that it projects 1900 Health Card members in the 2019-2020 funding year.

To reiterate, counsel recommends consideration of modifying the financial terms of the 2005 agreement, but does not recommend a fundamental restructuring that gives the appearance of shifting responsibility for maintaining quality ER services from the hospitals to WVHA, and establishes a direct relationship that might result in other physicians citing that new contract as a precedent for establishing their own direct contractual relationship with WVHA.

Following the Board's rejection of EMPros' request for a separate contract and funding during its Tentative Budget Hearing/Meeting and counsel's drafting a 14th Addendum that was satisfactory to the hospitals, EMPros waited until the October Regular Meeting to object to the draft on grounds that reimbursement rate was below the market. On October 29th, counsel sent EMPros and the hospitals a proposal to modify the draft 14th Addendum to specify the current Medicaid rate or whatever EmPros certifies is the lowest rate it accepts from any other payer, public or private, for similar services. As of this writing, counsel has received confirmation from both hospitals that they would accept the proposed resolution, but has only received a note from EmPros saying that its board will meet today to decide on its position. To the extent that EmPros continues pressing for a higher rate, it is worth reiterating what so often is missing from its advocacy before the Board; that is, paying for ED Visits is the responsibility of the hospitals, NOT WVHA, under the Emergency Medicine Treatment & Labor Act (EMTALA). It is beyond puzzling why all these years EmPros has been willing to accept a lower than Medicaid rate when it believed those reimbursements were coming from Adventist hospitals but is now pressing for Medicare or higher rates now that it knows the reimbursements will come from West Volusia taxpayers.

III. Downtown DeLand CRA: Notice of Amendment to Extend CRA Expiration from September 30, 2025 to December 31, 2036. [*See new info. in italics and bold*] [*Refer back to Legal Update Memorandum dated 3/21/19 for additional background details.*]

The City Commission formally considered and rejected WVHA exemption request at the June 17th City Commission meeting. Counsel forwarded to Board members an electronic copy of the City's formal notice of its denial of the request in an email dated August 1, 2019. The notice of denial mentions twice that the City desires to maintain a good community partner relationship with WVHA and invites WVHA to reapply for the exemption closer to the start of the Extension Period, which runs 2025-2036. Nevertheless, the City denied the request and adopted the staff analysis of the statutory factors that it was required to consider. In a nutshell, the City's analysis of the Section 163.387(d)(2) factors acknowledges that the CRA has no bond or other debt, no special projects at all within its approved plan, much less any CRA projects that would benefit the provision health care or access to health care. Both of these factors should have been weighted in favor of the requested exemption. Instead, the City's analysis is focused solely on the fiscal impact factor, i.e., the loss of a future revenue stream which the CRA could possibly need in the future if it subsequently approves special projects or incurs debt. The analysis in the notice of denial also undervalues the degree to which the health care access outreach programs of Rising Against All Odds, The Neighborhood Center and Hispanic Health Initiative target potentially unhealthy and homeless residents and provide them with a means to get off the streets of the Downtown DeLand area and access health, housing and welfare programs. Using the City's analytical emphasis on the uncertainty of fiscal impact of lost future revenue, it is hard to imagine how any entity would ever qualify for an exemption under Section 163.387(d)(1). It is doubtful that this was the intent of the Legislature to have this provision be a nullity as applied. Counsel continues to explore alternative strategies for obtaining the exemption requested and denied by the City from this extension of the CRA tax; counsel will update the Board as appropriate.

IV. WVHA as Plaintiff in Federal Multidistrict Litigation for National Prescription Opiate Litigation, James Vickaryous, Managing Partner of Vickaryous Law Firm. [*See new info. in italics and bold*]

Counsel talked preliminarily with Jim Vickaryous, the Managing Partner of the **Vickaryous Law Firm** about WVHA retaining his law firm to represent WVHA on a contingency basis and file a lawsuit on behalf of WVHA in the federal multidistrict litigation for national prescription opiate litigation. Attorney Vickaryous plans to present a formal proposal to explain the details, but in a nutshell the proposed representation would offer WVHA a seat at the table among many other governmental and private entities around the nation that are suing pharmaceutical companies. These lawsuits are seeking to recover damages related to the substantial health care and prescription costs that have been paid to treat residents who became addicted to opioids. As of this writing, counsel has not yet received a draft of the proposed retainer agreement or the presentation materials. Attorney Vickaryous has indicated in an introductory call that if desired, WVHA would become one of several Florida based local government clients which his firm would represent. The contingency basis of the representation would provide that the Vickaryous Law Firm would be paid 20% of any net recovery after costs and WVHA would keep the remaining 80%. Attorney Vickaryous believes that it would be important to get WVHA's lawsuit on file as soon as practicable before settlement talks begin and conclude concerning a Tier 1 lawsuit that is scheduled for trial in Ohio during October, 2019. Attorney Vickaryous believes that the defendants in that lawsuit

may want to negotiate a global settlement of all pending lawsuits and it would be advantageous for WVHA to have a seat at that table, particularly in light of the substantial annual budget expenses being paid to SMA and for prescriptions that are directly related to the opioid epidemic. Counsel expects to receive and review the details prior to the March meeting and have a recommendation as to the form of the retainer agreement at that time. As an overall matter, the proposal sounds like a potential opportunity for WVHA to recoup substantial taxpayer dollars, but it may take some time before any recovery is obtained. Following the Board's authorization of Chair Craig to sign the proposed contingency agreement subject to a clarification that the net of any recovery to WVHA only be reduced to reimburse "reasonable" attorney's fees, Chair Craig has executed the revised agreement and it is being circulated for signatures by all the retained co-counsel. As previously emailed, WVHA's complaint in the national opioid litigation was initially filed in federal court in the Middle District of Florida on September 10, 2019. On September 26, 2019, that case was transferred to the Northern District of Ohio where is has been consolidated with the thousands of other pending cases in that multidistrict opioid litigation.

V. General Compliance with the Sunshine Law [*See new info. in italics and bold*]

The Government in the Sunshine Law, section 286.011, Florida Statutes, provides in pertinent part:
"All meetings of any board or commission . . . of any agency or authority of any county, municipal corporation, or political subdivision . . . at which official acts are to be taken are declared to be public meetings open to the public at all times, and no resolution, rule, or formal action shall be considered binding except as taken or made at such meeting."

It is impossible to summarize all relevant points of the Sunshine Law, but please note that courts uniformly interpret this provision as prohibiting two or more members of the same board or commission from talking about or discussing any matter on which *foreseeable* action will be taken by the pubic board or commission. (If your conversation with another board member concerns personal or business matters unrelated to the Authority, the Sunshine Law does not apply)

Please note that the Sunshine Law DOES apply to "off-the record" chats during meetings or during breaks, written correspondence, telephone conversations and e-mails exchanges between two or more board members if such communication concerns matters likely to come before the Board; provided however, it is permissible for one board member to send correspondence to the rest of the board outside of a public meeting as long as this correspondence does not result in replies or other back and forth exchanges until a public meeting is convened for such discussion and also the correspondence is made available to interested members of the public.

The Sunshine Law also prohibits nonmembers (staff, lawyers, accountants, and members of the public) from serving as liaisons between Board members concerning matters likely to come before the Board.

With the increased use of social media accounts, including Facebook and other community and political blogs, Board members should be mindful of the following Florida Attorney General guidance before posting on Facebook, or other blogs an opinion or viewpoint on matters likely to come before the Board. In AG Opinion 08-07, the Florida Attorney General concluded that the use of a website blog or message board to solicit comment from other members of the board or commission by their response on matters that would come before the board would trigger the requirements of the Sunshine Law. As stated therein:

> *"While there is no statutory prohibition against a city council member posting comments on a privately maintained electronic bulletin board or blog,... members of the board or commission must not engage in an exchange or discussion of matters that foreseeably will come before the board or commission for official action. The use of such an electronic means of posting one's comments and the inherent availability of other participants or contributors to act as liaisons would create an environment that could easily become a forum for members of a board or commission to discuss official issues which should most appropriately be conducted at a public meeting in compliance with the Government in the Sunshine Law. It would be incumbent upon the commission members to avoid any action that could be construed as an attempt to evade the requirements of the law."*