



United Medical Center Not-For-Profit Hospital Corporation: History, Current Status, And Next Steps

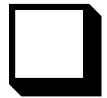
Presentation :

Retreat Of United Medical Center Not-For-Profit Corporation Board of Directors

Presentation Outline



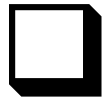
**The Path To District Ownership Of United Medical Center
Not-For-Profit Hospital Corporation**



Current Status Of United Medical Center

Operational Issues

Financial Status



Next Steps

Goals For United Medical Center

Prior Partnership Efforts

Status of Site Selection Work

Procure Health Care Consulting Services

The District's Public Safety Net Health Care System Was Organized Under A Public Benefit Corporation (PBC) in 1996

DC Government

\$45M

Public Benefit Corporation

Operating Environment

- Roughly 19% of the District's residents uninsured
- DC General provided more than one-third of all uncompensated care in the city
- One FQHC, one "lookalike" FQHC, and several community health clinics in network – all primary care for uninsured
- System designed to receive annual appropriation from District government

Commercial and Publicly-Funded Insurers

\$

\$

Publicly-Funded Insurers

\$

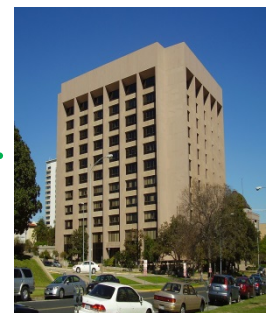
DC General Hospital

\$

Federal Qualified Health Center and 7 Clinics

\$

\$



Almost Immediately The PBC Began Experiencing Financial Problems In Overseeing The Public Safety Net Health Care System

- ❑ DC General Hospital entered the PBC with several years of running deficits. The reasons:
 - ❖ No integration of clinic care with hospital care
 - ❖ Massive emergency room overcrowding encouraged patient flight
 - ❖ Utilization by patients with 3rd party insurance sharply declined
 - ❖ Growing numbers of uninsured, including non-DC residents accessed the system
 - ❖ Bloated hospital cost structure due to serious overstaffing
 - ❖ Physicians on payroll full-time while operating private practice
 - ❖ No record keeping infrastructure
 - ❖ Low Medicaid reimbursement rates
 - ❖ Medicaid billings rejected due to poor documentation and unjustifiable use of inpatient care
 - ❖ Deteriorating conditions caused flight of Board-certified physicians
 - ❖ No positive cash flow from the hospital operations to fund a PBC reserve
- ❑ By 2000 the hospital carried a \$100 million deficit and the PBC was consuming its entire \$45 million annual subsidy from the District in only six months
- ❑ It was later discovered that the hospital was booking bad debt as collectable receivables which pushed the PBC into insolvency

In September 2000 House Subcommittee Charged The District of Columbia With Violation of Anti-Deficiency Act

□ House Subcommittee ruled that for fiscal years of 1997- 2000, the District and the PBC violated the Anti-Deficiency act in two ways:

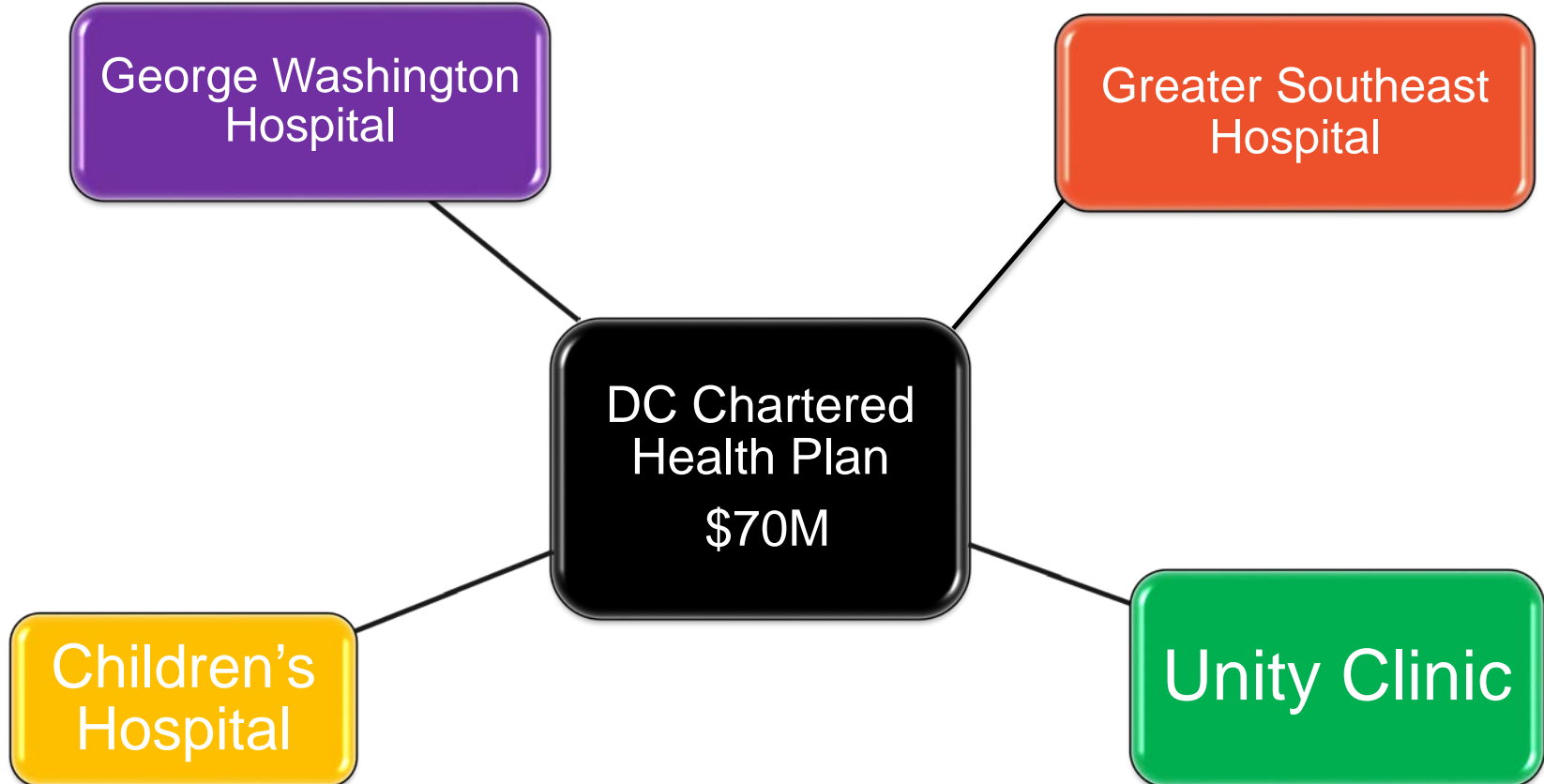
1. The PBC violated the Anti-Deficiency Act by obligating more than the Congress appropriated
2. The PBC and the District of Columbia violated the Anti-Deficiency Act by using the District of Columbia General Fund to pay liabilities of the PBC in excess of the resources PBC ultimately realized

Control Board Takes Action

- ❑ In 2000 Control Board issues mandate forcing the District to address problems of DC General
 - Orders closure of DC General trauma unit
 - Prohibited any more deficit spending at hospital
 - Directed the District to establish a health care delivery model for the uninsured that was financially responsible and offered the promise of quality care

Mayor Anthony Williams Establishes The Insurance Based Health Care Alliance Program For The Uninsured In 2001

The Health Care Alliance



The District's Turbulent Route To Ownership Of The United Medical Center

Trouble For Greater Southeast

- Financier for hospital files for bankruptcy (2002)
- Hospital stays open but day-to-day operations suffer – supply & staff shortages
- Hospital loses its license and must operate with provisional license (2003)


DC Council Forces Sale Of Greater Southeast

- Owners of Greater Southeast sell to Specialty Hospitals of Washington (2007)
- Specialty Hospital had weak financials and a questionable operating plan
- District provides \$100 million in assistance through loans and grants
- Board rebrands the hospital naming it United Medical Center Not-for-Profit Corp.


Specialty Defaults On Loans And City Purchases UMC

- UMC struggles despite infusion of cash – aging physician base, supply shortages, huge monthly losses
- Losses mount at Specialty Hospital which is unable to repay the City a \$20 million loan
- City reverses plan to put the hospital into receivership and holds an auction
- The District was the only bidder, acquiring UMC by forgiving the \$20 million loan
- Council created a Board to set policy and provided the hospital with \$26 million in budget authority

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The Problems At United Medical Center Did Not End Under The Ownership Control Of The District

- ❑ UMC regained accreditation under the District's Control but the operational and fiscal challenges continued unabated. They included:
 - An absence of strategic plan to guide the future direction of hospital;
 - Reliance on an outdated and expensive business model - a large configuration of inpatient beds;
 - Lack of financial and reporting tools to support the hospital's service or product lines;
 - Physician compensation packages that exceeded revenue by nearly \$10 million annually;
 - A badly broken revenue cycle operation resulting in delayed billing collection, increases in patient account receivables, and a strained cash position for the hospital

As A Result Most Medicaid Spending On Secondary And Tertiary Care For Residents In Wards 7 & 8 Escapes UMC

80.2% To Providers
In Other Wards
(\$484.4M)

19.8% To UMC
Hospital
(\$119.9M)



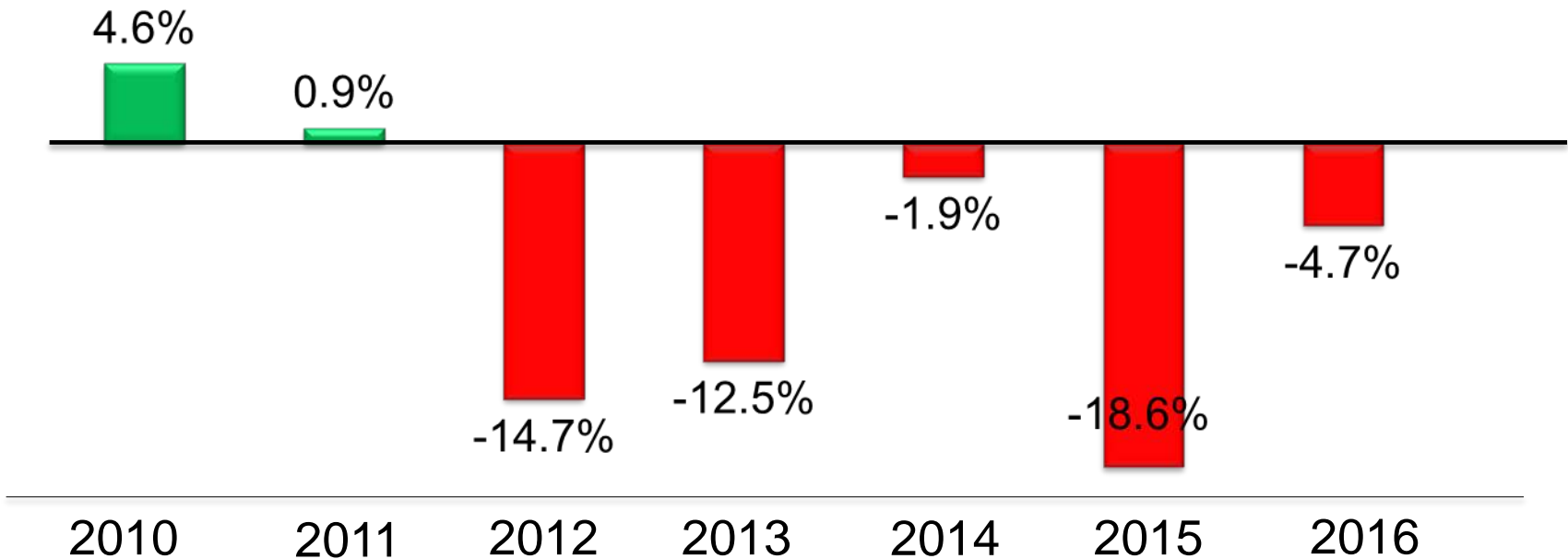
Note: Medicaid and Alliance spending are included in these totals and they reflects payments made to providers in FY2016 for managed care and fee-for-service members for inpatient, outpatient, and non-primary care physician services.

Source: Medicaid Management Information System (MMIS)

United Medical Center Not-For-Profit Hospital Corporation Audited Financial Statements, 2010-2016.

The Operational And Fiscal Challenges Are Reflected In The Worsening Operating Margins For United Medical Center

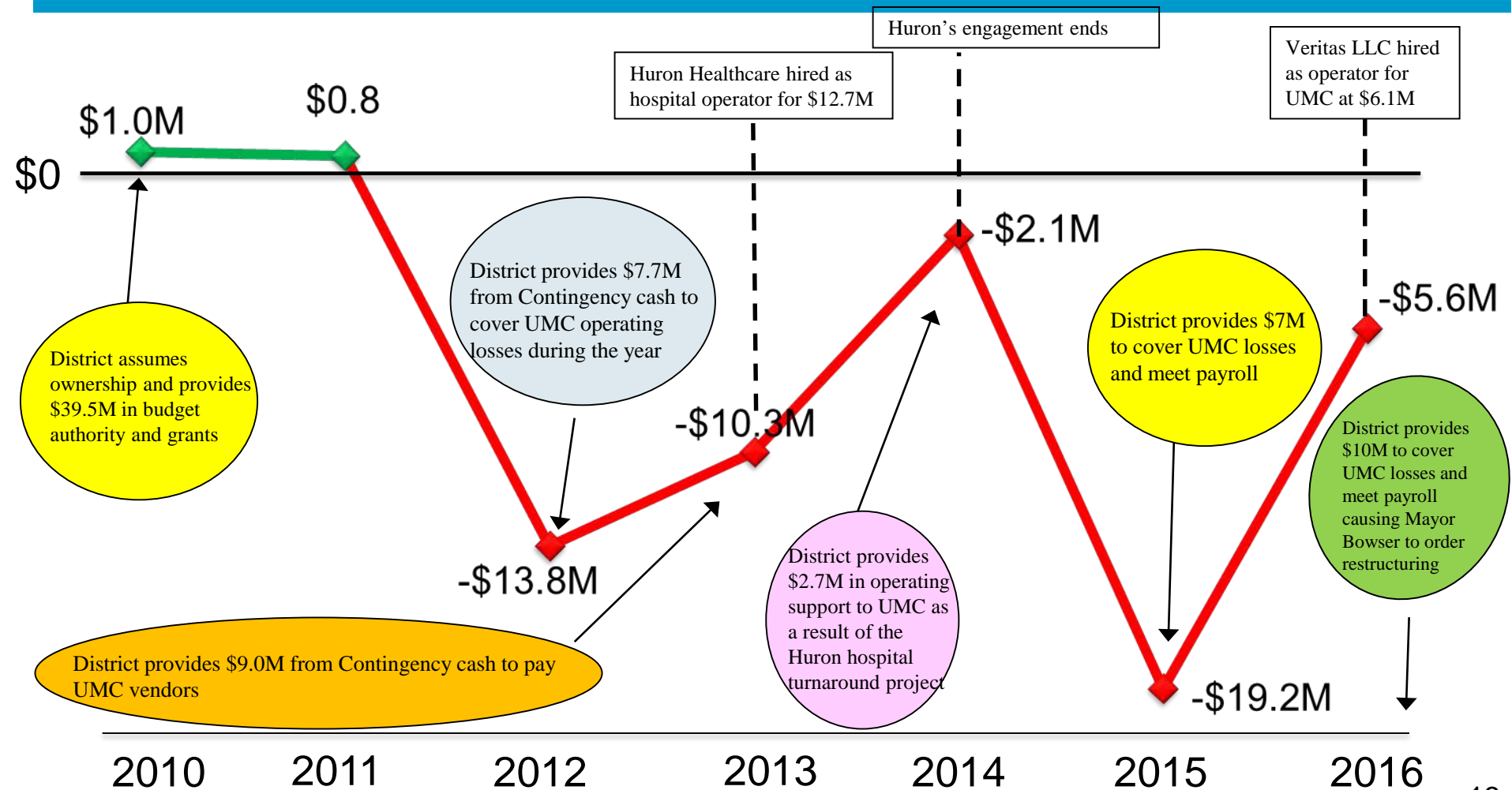
United Medical Center Operating Margins, 2010-2016



Note: Operating margin is a measure of profitability calculated by dividing net operating income by operating revenue. Thus, this measure indicates how much each dollar of operating revenue remains after operating expenses are considered. A negative operating margin for UMC of 18 percent in 2015 for example, means that for every dollar of revenue the hospital collected that year, it lost 18 cents.

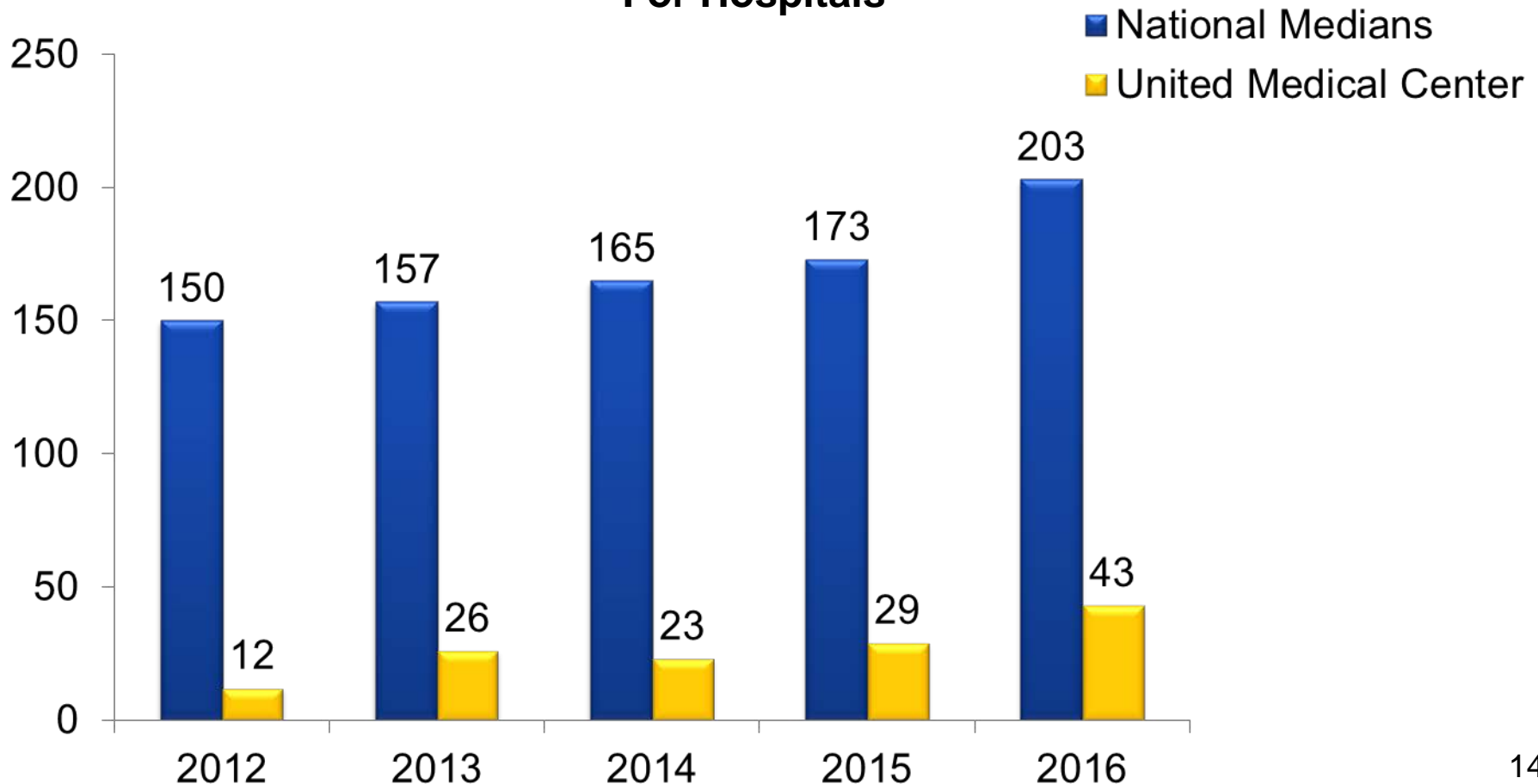
Source: United Medical Center Not-For-Profit Hospital Corporation Audited Financial Statements, 2010-2016.

UMC's Operating Losses Have Required Significant Cash Infusions From The District



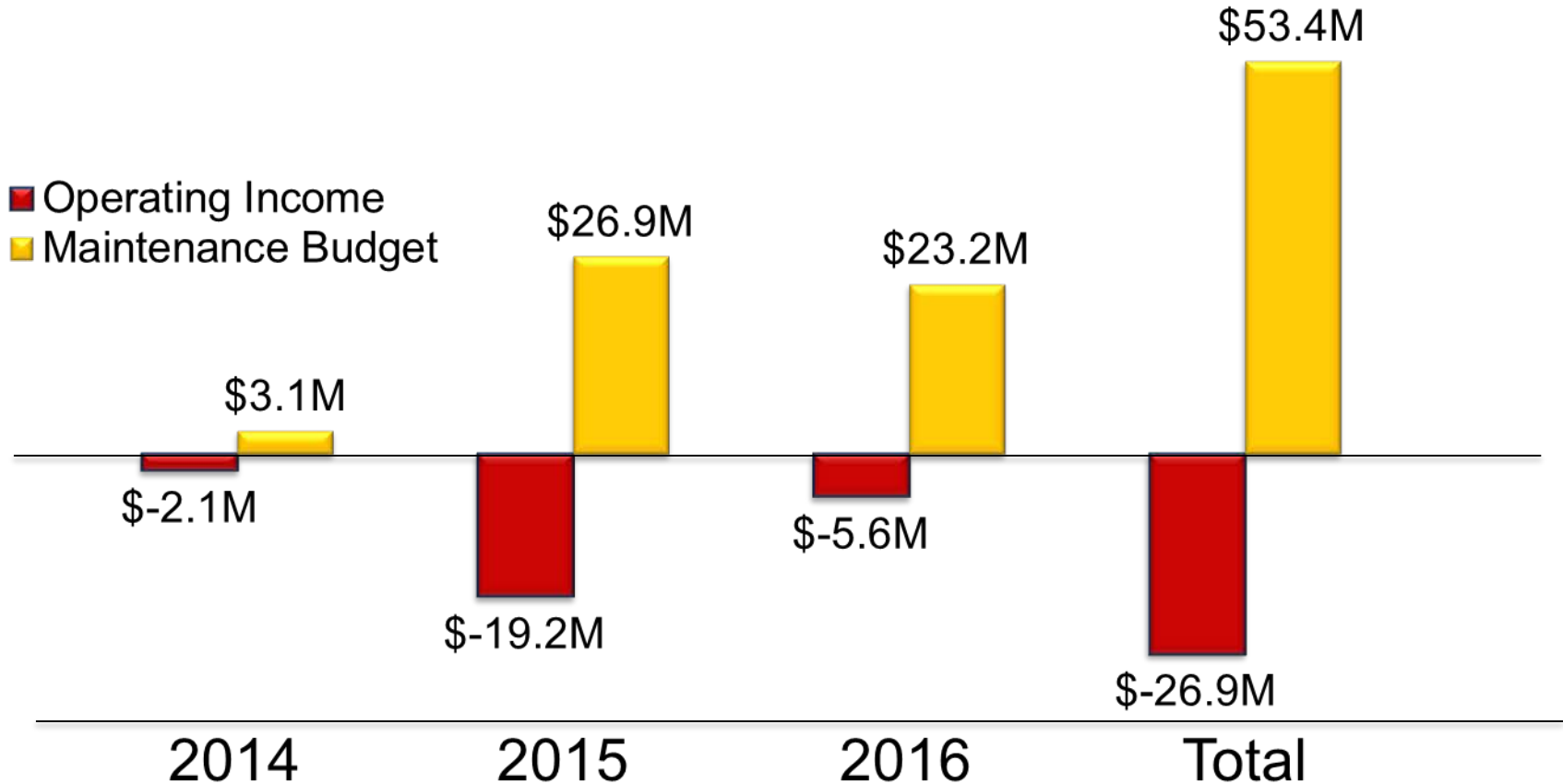
Financial Support From The District Has Improved UMC's Cash Position Over The Last Four Years But It Remains Far Below The National Norm

Comparison Of UMC's Cash-On-Hand (In Days) To National Medians For Hospitals



With Consistent Year-to-Year Operating Losses, UMC Officials Continues To Require Annual Subsidies From The District To Address The Maintenance Needs Associated With Its Aging Infrastructure

United Medical Center Maintenance Budget Compared To Operating Income, 2014-2016



Note: Operating income calculation is net of operating expenses, including depreciation.

Source: United Medical Center Not-For-Profit Hospital Corporation Audited Financial Statements, 2014-2016.

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Bowser Administration Goals For UMC

- ❑ The Bowser Administration has four broad goals for UMC
 1. Stabilize operations and end annual financial losses
 2. Limit non-portable capital investments to those required to ensure public safety and meet code requirements
 3. Pursue a partnership model that offers the promise that UMC will operate without District government intervention and free from public subsidy
 4. Explore potential sites for a replacement hospital for UMC

Veritas, LLC Hired To Right Size UMC Cost Structure And Streamline Capital Budget Requests

- ❑ In April 2016, the UMC Board secured the services of Veritas as hospital operator. Subsequently Veritas -
 - Finalized the execution of a hospital restructuring plan for FY2016 and begin work to reexamine capital budget requests to reflect long-term plans for UMC
 - Developed a Management Action Plan (MAP) – pegged to a Board-approved budget -- to guide the long-term operation of the hospital
 - The MAP employs a series of measures which reflect key operational metrics for a hospital
 - ❖ Performance for each metric compared to targets
 - ❖ Trends examined
 - ❖ Variances investigated and necessary operational adjustments employed
- ❑ These metrics help gauge the condition of hospital operations and provide early warning signs of any financial trouble

Nonetheless, Earlier Assessments Concluded That UMC Will Not Likely Reach Self-Sufficiency Without A Strong Partner

- In June 2013, a consultant completed a strategic assessment of UMC and offered six different scenarios for the future of the hospital
 - **Scenario 1 – Close UMC** – This was top “rated” scenario financially with lowest implementation risk but it imposed significant operational, health care, political, and employment challenges
 - ❖ Loss of access to acute care for Ward 7 & 8 residents versus the financial benefits of closure are not easily quantified but are clearly negative
 - **Scenario 2 - Status Quo** – Not a realistic option – represents a “going out of business” strategy
 - ❖ District’s continual support would likely exceed \$10-15 million annually for the foreseeable future and this could ultimately result in closure

A 2013 Assessment Concluded That UMC Will Not Likely Reach Self-Sufficiency Without A Strong Partner (continued)

- **Scenario 3 – Divestiture** – Unlikely to draw interest from new ownership until operating performance and market position are significantly improved
 - ❖ District needs to address structural problems in hospital to facilitate any alignment model
 - ❖ District would need to guarantee certain reimbursement levels in some manner
 - ❖ Additionally, UMC would need to be in a network for long-term sustainability of this approach

A 2013 Assessment Concluded That UMC Will Not Likely Reach Self-Sufficiency Without A Strong Partner (continued)

- **Scenario 4 – Focused Community Hospital** – Balances services between financial sustainability and value to community
 - ❖ Potential to maintain some hospital benefits to Ward 7 & 8 residents – strengthen core services
 - ❖ With no regional network and implementation risk, this approach could ultimately lead to divestiture but more likely closure

- **Scenario 5 – Limited Service Hospital** – Small number of profitable inpatient specialty care services
 - ❖ Dependent on achieving a high proportion of procedural volumes and a disproportionate base of commercial and Medicare insurance

A 2013 Assessment Concluded That UMC Will Not Likely Reach Self-Sufficiency Without A Strong Partner (continued)

- **Scenario 6 – Ambulatory Only** – Opportunity to improve outpatient access for Ward 7 & 8 residents but loss of inpatient and specialty services would adversely impact community
 - ❖ Roughly 4,100 residents in the primary service area are admitted to UMC annually and thus would be forced to seek inpatient care outside Wards 7 & 8. Others -- approximately 85 percent of residents in Wards 7 & 8 – who already travel across Wards for care would be forced to permanently continue to do so
 - ❖ Would be a challenge to generate profits given high percentage of visits from DC Medicaid enrollees – constrained to no better than a break-even model under the best of circumstances. District would likely need to create mechanism to fund ongoing operations
 - ❖ Significant operational, health care, political, and employment challenges with loss of inpatient care

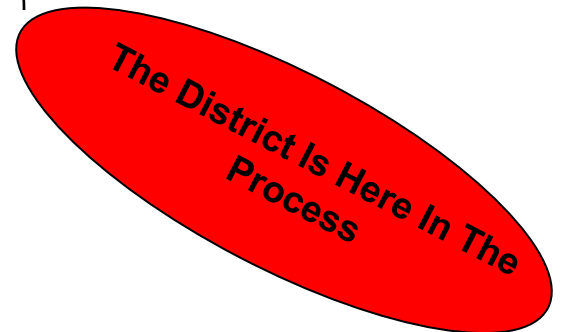
While Stabilization -- Including Physician Recruitment -- Is Underway With Veritas As The Operator, Partnership Opportunities Appear Limited At This Time

Potential Regional Partners	Current Status	Partnership Prospects Under Current Conditions
Entity 1	No band width -- given partnership with XXX -- or appetite for risk	Unlikely
Entity 2	Expressed limited interest in only a surgical center	Unlikely. Also would not accept existing staff
Entity 3	No interest because of UMC's losses. Rumored to be pursuing access to XXX's physician practice	Unlikely. This view could shift if UMC's bottom line improves
Entity 4	Interest is very high but XXX now admits that company lacks necessary capital	Not recommended
Entity 5	No initial interest. Had discussions with XXX but new XXX CEO recently met with DHCF and "wants to be in conversation".	Has some potential. Very concerned that City will build a new safety net hospital, "sinking both XXX and XXX".
Entity 6	Interest is very high but they have no plans to contribute capital. Recently approached the District with a potential partner. However, no proposal on the table and parties would like to vet UMC to determine investment risk	Not likely without a capital partner. While other synergies exist, they come with high risk of failure and greater cost for the District. Inclusion of a willing and adequately capitalized partner is a must

Mayor Bowser Has Authorized A Site Selection Study Which Is Embedded Within A Multi-Phase Process That Could Support A Design And Build Of A Replacement Hospital

❑ Most companies involved in hospital construction pursue an integrated design-build method that can involve up to six independent phases

1. Assessment of proposed sites – 30 days per site
2. Hospital size and service mix – 60 days
3. Schematic design – 90 days
4. *Design Development – 90 days
5. Construction documents – 90 days
6. Hospital construction



The District Is Here In The Process

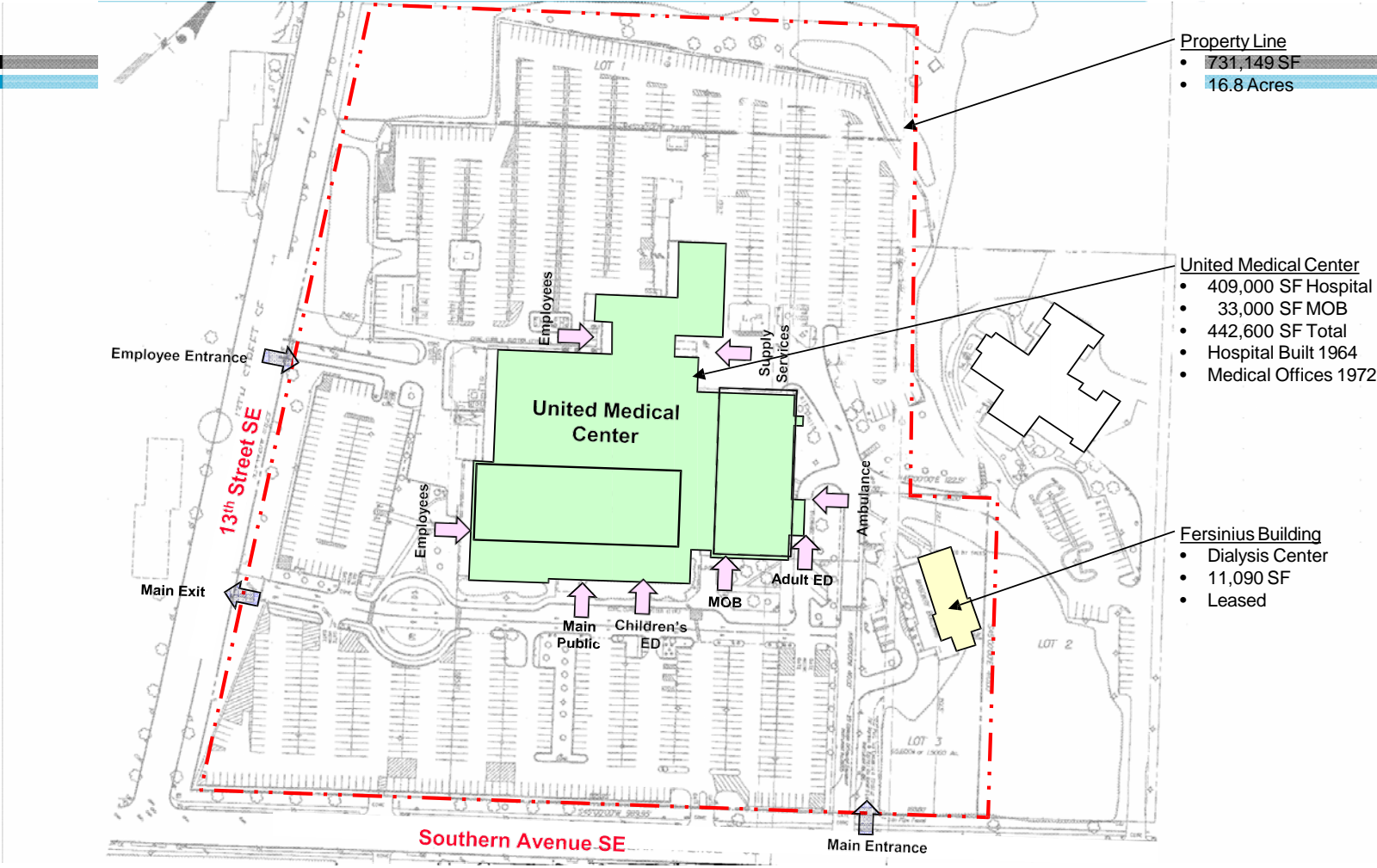
* Experts indicate hospital construction will cost from \$1.5MM to \$2.0MM per inpatient bed

Very Preliminary Work Has Been Completed To Evaluate The Feasibility Of Several Possible Sites For A Replacement Hospital

- ❑ Health Building Solutions (HBS) -- the company that built George Washington University Hospital -- has completed the first Phase of a site analysis study
 - Seven sites initially scored and top three sites selected for a Phase 1B Conceptual Site Study
 1. UMC
 2. St. Elizabeth's
 3. Fletcher Johnson

- ❑ Phase 1B work should be completed by late April to mid-May

Previous Consultants Have Concluded That Due To Central Placement Of UMC, The Construction Of A New Hospital On The Existing Site Is Not Considered Practical Or Cost-Effective



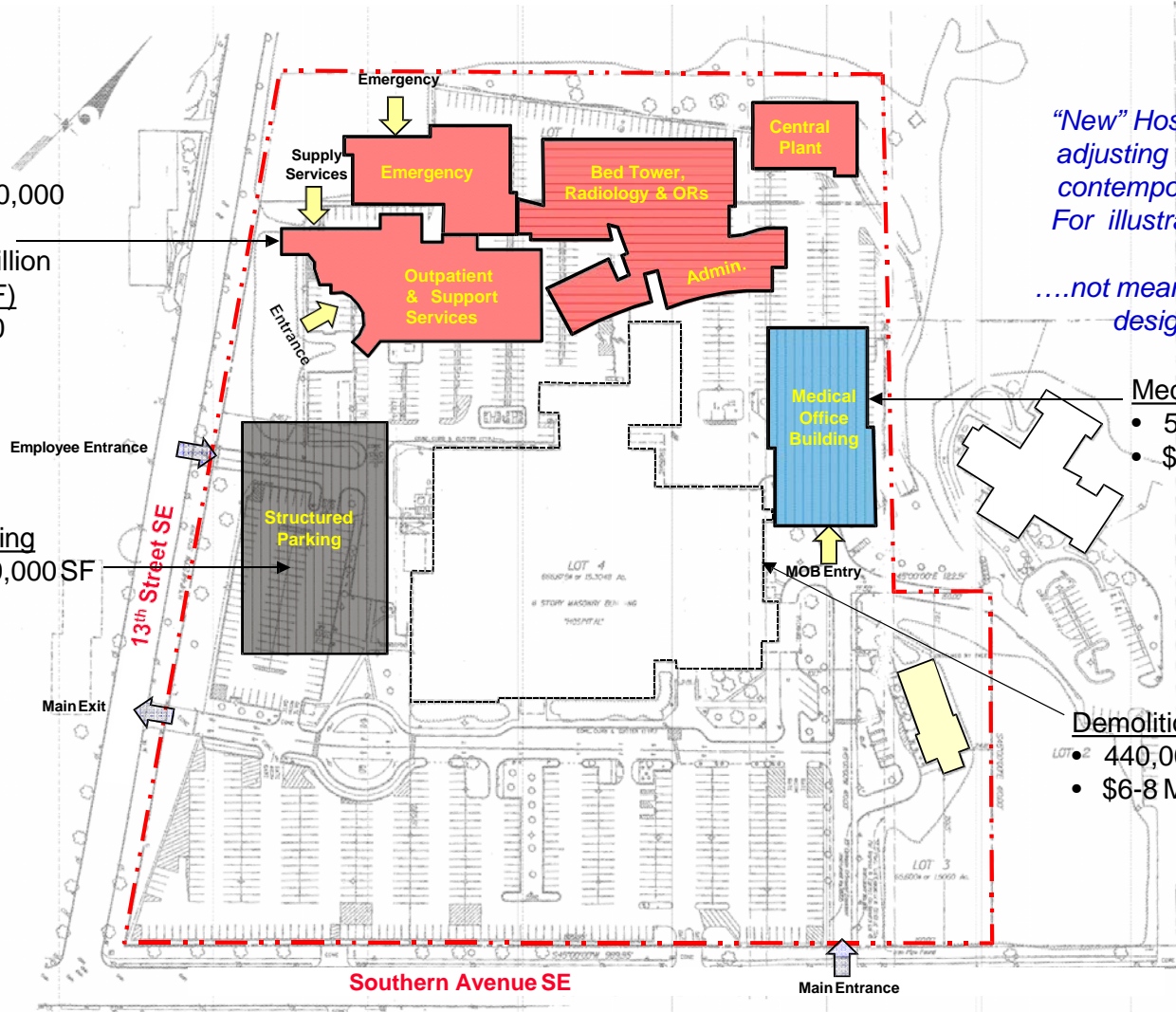
The Challenges Created For New Hospital Construction On The Current Site Are Numerous (continued)

New Hospital

- 300,000 – 330,000 SF
 - \$180 - \$230 Million
- ## Post Acute (SNF)
- 27,000-30,000
 - \$16-20 Million

Structured Parking

- 90,000 – 100,000 SF
- \$10 Million



*“New” Hospital based on adjusting the layout of a contemporary hospital¹. For illustration purposes only
....not meant to represent a designed plan.*

Medical Office Building

- 50,000 – 60,000 SF
- \$18-22 Million

Demolition Existing UMC

- 440,000 SF
- \$6-8 Million

The Challenges Created For A New Hospital Construction On The Current Site Are Numerous (continued)

- ❑ A new hospital on the current site that included a main building, a medical office, parking, and a skilled nursing facility would require 377,000 to 420,000 square feet - this cannot be easily accommodated. Problems include -
 - ❖ Difficult to provide separate and convenient entries for patients, physicians and visitors and no link to an ambulatory facility
 - ❖ Difficult to provide separate and convenient access for emergency services, supply services and employees
 - ❖ Construction process is likely to be disruptive to ongoing operations
 - ❖ Longer construction time required to build around an existing occupied structure
 - ❖ Demolition of UMC required to accommodate parking, improved access, and site for future expansion - asbestos abatement must be completed prior to demolition
 - ❖ Capital costs are significantly higher than alternative scenarios

DHCF Released A RFP in February To Procure The Services Of A Health Care Consultant To Inform Planning For A Replacement Hospital – Bids Are In

□ Focus of project to include –

- Analysis of changes in healthcare policy -- reimbursement, technology, new approaches to health care delivery -- and how these changes are likely to impact future inpatient admission rates, average lengths of stay, use of outpatient care, and emergency room visits in the District of Columbia;
- A market analysis on inpatient and outpatient trends for other health care systems in the District of Columbia to inform recommendations regarding the most appropriate hospital design for a replacement hospital in Wards 7 and 8;
- The range of financing options available to the District of Columbia; and
- An assessment of the possibility of viable partnership arrangements for the District, along with an analysis of the various management archetypes for a new hospital which ultimately removes the District from its current role of hospital operator.

Project Will Conclude This Fall

- ❑ The RFP will require multiple deliverables over the course of the project
- ❑ The comprehensive report will draw together the findings from each deliverable into one document
- ❑ Report should be completed by September of 2017