

<b>SOLICITATION, OFFER, AND AWARD</b>		1. Caption Hospital Operator Services		Page of Pages	
				1	35
2. Contract Number	3. Solicitation Number	4. Type of Solicitation <input type="checkbox"/> Sealed Bid (IFB) <input checked="" type="checkbox"/> Sealed Proposals (RFP) <input type="checkbox"/> Sole Source <input type="checkbox"/> Emergency	5. Date Issued 11/28/2017	6. Type of Market <input checked="" type="checkbox"/> Open <input type="checkbox"/> Set Aside <input type="checkbox"/> Open Market with Set-Aside CBE Designated Category	
7. Issued By: Department of Health Care Finance 441 4 <sup>th</sup> St NW., Suite 900S Washington, DC 20001		8. Address Offer to: Kenneth L. Evans Chief Operating Officer and Deputy Chief of Staff Department of Health Care Finance 441 4 <sup>th</sup> St NW., Suite 900S Washington, DC 20001			

NOTE: In sealed proposal solicitations "offer" or "offeror" means "bid or "bidder"

**SOLICITATION**

9. Sealed offers in original and 1 copies for furnishing the supplies or services in the Schedule will via electronic format via Ariba E-Sourcing and mail directly to address above.  
12:00 p.m. EST. time 12/12/2017  
 (Hour) (Date)  
 CAUTION: Late submission, Modifications and Withdrawals: See 27 DCMR chapter 46 as applicable. All offers are subject to all terms & conditions contained in solicitation.

10. For Information Contact	A. Name		B. Telephone		C. E-mail Address
		(Area Code)	(Number)	(Ext)	
	Kenneth L. Evans		202	442-8436	

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12. In conjunction with the above, the undersigned agrees, if this offer is accepted within 120 calendar days from the receipt of offers specified above, to furnish any or all items upon which prices are offered at the price set opposite each item, delivered at the designated point(s), within the time specified herein.

13. Discount for Prompt Payment	10 Calendar days %	20 Calendar days %	30 Calendar days %	___ Calendar days %
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14. Acknowledgement of Amendments (The offeror acknowledges receipt of amendments to the SOLICITATION):	Amendment Number	Date	Amendment Number	Date

15A. Name and Address of Offeror	15B. Telephone			16. Name and Title of Person Authorized to Sign Offer/Contract	
	(Area Code)	(Number)	(Ext)	17. Signature	18. Award Date

**AWARD (TO BE COMPLETED BY GOVERNMENT)**

19. Accepted as to Items Numbered	20. Amount	21. Accounting and Appropriation
2. Name of contracting Officer (Type or Print)	23. Signature of Contracting Officer	24. Award Date

**SECTION B: CONTRACT TYPE, SUPPLIES OR SERVICES AND PRICE/COST**

**B.1** The Department of Health Care Finance (the “District”), is seeking a Contractor to provide the services of a qualified Contractor to implement turnaround operations of UMC.

**B.1.1.** “UMC” or “Hospital” shall mean the Not-for-Profit Hospital Corporation’s acute care hospital, skilled nursing facility, and clinics, located at 1310 Southern Ave, SE, Washington, DC, 20032, and as more precisely defined in D.C. Official Code §§ 44-951.01 *et seq.*

**B.1.1** “RFP Issuer” shall mean the District, and/or, UMC, as applicable

**B.2** The RFP Issuer contemplates award of a **Firm-Fixed Price Contract**.

**B.3 PRICE SCHEDULE**

<b>Contract Line Item No. (CLIN)</b>	<b>Reference Section</b>	<b>Line Item Description</b>	<b>Total Price</b>
1	C.5.1	Conduct assessment of Hospital operations and develop a management action plan for the Board of Directors that reflects a strategy to operate within the projected revenues of the Hospital.	\$_____
2	C.5.2	Assess adequacy of Hospital Organizational Structure to achieve and sustain necessary performance improvements and implement required personnel changes to improve Hospital operations	\$_____
3	C.5.3 C.5.4	Work with the Office of the Chief Financial Officer to improve revenue cycle, cash flow management and accounts receivable operations. Submit quarterly progress reports with performance against metrics to the Board of Directors.	\$_____
4	C.5.5 C.5.5.1 C.5.6	Conduct a thorough review of program development with the goal of aligning physicians, nurses and staff around delivering healthcare services to produce best outcomes. The Contractor shall conduct a thorough review of clinical policies and practices with a goal of aligning with best practice standards, ensuring adequate staff and vendor training, reducing the severity and frequency of poor quality outcomes, and improving the overall patient experience. Pursue cost savings through both clinical and operational performance improvements, including updates to Hospital MCO contracts.	\$_____

5	<p>C.5.7 C.5.8 C.5.8.1 C.5.8.2 C.5.8.3 C.5.8.4 C.5.8.5 C.5.8.6 C.5.8.7 C.5.8.8</p> <p>C.5.9</p>	<p>Conduct a labor analysis and review budgeted staffing and structure to determine appropriate use of resource to ensure optimal use of staff to achieve improvements in efficiency, as well as patient and staff satisfaction.</p> <p>Analyze key operating metrics including: patient admissions, discharges, adjusted patient days, adjusted man hours per patient day, outpatient visits, average length of stay, CMI, percentage of surgical admissions and occupancy levels.</p> <p>Based on these results, develop and implement rational staffing recommendations for staff and management throughout the organization.</p>	<p>\$ _____</p>
6	<p>C.5.10 C.5.10.1 C.5.10.2 C.5.10.3 C.5.10.4 C.5.10.5 C.5.10.6 C.5.10.7 C.5.10.8 C.5.10.9</p>	<p>Conduct a detailed review and analysis of supply chain and contracts, to identify areas where change in process, purchasing agreements, or contracts, will yield meaningful savings, focusing on the following areas:</p> <ul style="list-style-type: none"> <li>• Materials management policies, procedures and work flow</li> <li>• Supply and resource utilization with a focus on high cost and high-volume areas</li> <li>• Pricing analysis with a focus on high cost and high-volume areas</li> <li>• Review of purchased service agreements and relevant supply agreements</li> <li>• Opportunity for more centralized supply chain functions</li> <li>• Standardization of medical and surgical supplies to drive down cost</li> <li>• Utilization of contract database to assist with contract administration</li> <li>• Review all contracts for goods and services for cost-savings, efficiencies, and compliance with applicable federal and local laws and regulations, including Stark and AKS.</li> <li>• Perform necessary trainings to ensure competency in Hospital and government contracting, especially for those with official contracting duties i.e. COTR, CO.</li> </ul>	<p>\$ _____</p>
7	<p>C.5.11</p>	<p>Evaluate the performance of the newly hired emergency department, hospitalist, and intensivist in delivering quality care while filling the historical gaps in physician specialty.</p>	<p>\$ _____</p>

8	C.5.12	Identify and make recommendations for IT improvements Hospital wide.	\$ _____
9	C.5.13	Participation in Council /Stakeholder hearings and Meetings.	\$ _____
<b>Total Contract Price</b>			\$ _____

**B.4** An offeror responding to this solicitation which is required to subcontract shall be required to submit with its proposal, any subcontracting plan required by law. Proposals responding to this RFP may be rejected if the offeror fails to submit a subcontracting plan that is required by law. For contracts in excess of \$250,000, at least 35% of the dollar volume of the contract shall be subcontracted in accordance with section H.9.

A Subcontracting Plan form is available at <http://ocp.dc.gov>, under Quick Links click on "Required Solicitation Documents".

## SECTION C: SPECIFICATIONS/WORK STATEMENT

### C.1 SCOPE:

**C.1.1** The Not-For-Profit Hospital Corporation (“NFPHC”), an instrumentality of the District of Columbia government, operates the acute healthcare facility commonly referred to as United Medical Center (“UMC”) in southeast Washington, DC, as well as the skilled nursing facility, clinics and medical office building, all located on the site (collectively referred to as “Hospital”). “Site” shall mean 1310, 1328, and 1350 Southern Ave SE, Washington, DC 20032, and as more precisely defined in D.C. Official Code §§ 44-951.01 et seq.

Committed to providing exemplary service to its patients, the Hospital has equally high expectations of its business partners. It is expected that Contractors responding to this RFP will provide the highest quality service at the best value to the Hospital and, if applicable, to its patients and that the services will be provided in a manner that exhibits the highest level of ethics and professionalism. It is expected that, should a contract be awarded as a result of this RFP effort, that the Contractor will work with the Hospital to ensure that the agreement remains competitive with continual review of market conditions.

To be eligible to respond to this RFP, responding Contractors must demonstrate that it has successfully completed services similar in scope and timeframe to those specified in this RFP to healthcare organizations similar to the Hospital in size and complexity.

**NOTE: The Hospital is an independent entity within the District of Columbia government, not a 501(c)(3).**

### C.2 APPLICABLE DOCUMENTS

The following documents are applicable to this procurement and are hereby incorporated by this reference:

Item No.	Document Type	Title	Date
1	Report	RSM McCladrey Report	2011
2	Report	Huron Strategic Plan	2013
3	Report	Veritas Management Action Plan	2016
4	Power Point	DHCF Presentation to Hospital Board	March 2017
5	Report	Month OCFO-DHCF Veritas Financial Performance Reports	Monthly
6	Financials	FY 18 Budget	
7	Document	Testimony of Interim CEO before Council	October 2017
8	Document	Hospital Board Chair Remarks	November 2017

### C.3 BACKGROUND

**C.3.1** The Department of Health Care Finance (DHCF) is the District of Columbia’s state Medicaid agency. The mission of DHCF is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia. In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children, the State Child Health Insurance Program (CHIP) and the Alliance program - a locally funded health insurance program

for persons who are District residents but not citizens of the United States. Together, these programs provide health care coverage to more than 240,000 District residents.

A disproportionate number of these beneficiaries -- roughly 40 percent -- reside in Wards 7 and 8, experience significant health disparity issues, and are hampered by a health care delivery system in this Primary Service Area that is, at once, insufficient and marginally effective in delivering effective care to its residents. As one of the cabinet level agencies of District Government which focuses on health policy and health care management issues for Medicaid and Alliance recipients, DHCF has an interest in improved health outcomes for this population. Accordingly, DHCF wishes to propose to the City Administrator several options to improve the health care delivery system in Wards 7 and 8.

Prior to 2000 the District of Columbia's safety net health care system for providing primary, acute, and trauma health care services to low-income and uninsured residents consisted of DC General Hospital and a limited number of primary care clinics. In 1997, the hospital and clinics were managed by a Public Benefit Corporation (PBC) which was organized to operate as a quasi-independent entity empowered with greater control over the revenues and budget for the safety net system.

Since the District had yet to implement Medicaid expansion during this time, the rate of uninsured persons -- especially in Wards 7 and 8 -- was significantly higher than witnessed today. As a result, DC General provided more than one-third of all the uncompensated care delivered citywide. The network of clinics that supported the hospital under the umbrella PBC structure focused exclusively on the delivery of free primary care to many of the same patients served by the hospital; this, however, had severe limitations. Most notably, there was only one Federally Qualified Health Center joined by a small number of community clinics that simply did not have the capacity to meet the primary care needs of a rather substantial pool of uninsured residents. Moreover, none of these facilities offered access to specialty care physicians.

Although DC General had a long history of providing hospital-based care to residents in and around Wards 7 and 8, by the late 1990s, the hospital was in distress. A confluence of factors pushed the hospital to the brink of obsolescence. Notably, the physical plant was nearly 75 years old with outdated administrative systems and abysmal recordkeeping. This created serious problems with managing patient accounts and collecting receivables while undermining efforts to improve the operational efficiency of the hospital. Consequently, most commercially insured patients who used DC General began to seek their care from the other more effectively managed hospitals in the city.

As the patient census declined from the days when the hospital operated over 1000 beds, management did not respond with timely adjustments to the organization's clinical and service workforce. Moreover, the persistent and unabated deterioration in hospital conditions prompted an exodus of board-certified physicians fueling stories of poor quality care which came to dominate the news about the hospital.

Thus, by the end of the 20th Century, DC General was an expensive albatross around the neck of city finances as the PBC was practically insolvent. Reports at that time were that the PBC accounted for nearly 20 percent of the city's cumulative budget shortfalls during a period when the District operated under the restrictions imposed by the federally-appointed Control Board.

### **C.3.2 Reforms Adopted**

In 2000, following the election of Mayor Anthony Williams, the Control Board ordered the closure of DC General's trauma unit. Further, the Control Board directed the city to end deficit spending at the hospital and, as an alternative, establish a new and financially responsible model for health care delivery to the uninsured that offered the promise of quality care.

In response to this mandate, the newly elected Mayor took several bold steps aimed at improving the delivery of health care services for persons who relied on the PBC-managed safety net system. Specifically, Mayor Williams proposed a \$70 million insurance program for all uninsured adults with incomes less than 200 percent of the federal poverty level. These persons would receive an insurance card allowing the purchase of a full range of medical services from a consortium of public or private health care providers in the District of Columbia.

As a part of the plan, the Williams' Administration and the Control Board awarded a bid to Greater Southeast Community Hospital (GSCH) to provide access to a comprehensive set of health care services delivered through a confederation of hospitals and clinics. Although GSCH was experiencing financial troubles of its own at the time of the procurement, it faced competition from only one other bidder -- the even more troubled PBC -- so it was awarded the contract. This consortium that grew out of this arrangement, known as the Healthcare Alliance, consisted of George Washington University Hospital, Children's Hospital, Unity Health Care clinics, and one managed care organization - DC Chartered Health Plan.

In April of 2001, the Control Board finalized the contract presented by the Williams' Administration and not long afterwards completed the controversial process of closing DC General. Though politically charged, the closing of DC General was reflective of a national trend towards the privatization of public hospitals brought on by major contractions in the hospital industry. Thus, the new Healthcare Alliance, under the direction of GSCH, became operational giving uninsured residents in the District, for the first time, an option to purchase health care from hospitals, clinics, and private physicians who were not necessarily affiliated with the safety net system.

### **C.3.3 Impact of the 2000 Reform on Health Care Delivery in Wards 7 and 8**

Across most of the city, the reform of the District health care delivery system ushered in by Mayor Williams was quite successful in broadening the range and nature of health care services available to persons insured through the Healthcare Alliance. In addition, the financial bottom line for both hospitals and community clinics throughout the city benefited from serving patients once uninsured, but who now had insurance through a well-funded third-party administrator. This proved especially beneficial to community health centers. While there was still a paucity of specialty care clinics in certain parts of the city, the number of community health centers in Wards 7 and 8 grew substantially over the next 10 to 15 years.

Notwithstanding these positive changes, by all accounts, the potential impact of the reform on the health care delivery in Wards 7 and 8 was largely undermined by the myriad of problems encountered first, by GSCH, and then its ultimate successor, UMC. These entities' problems -- both financial and operational -- have left the residents of these two Wards with a struggling acute care hospital that has limited connections to community health centers and no meaningful nexus to critically important specialty care centers.

***The Bankruptcy of GSCH.*** In November 2002, the Corporation which owned GSCH filed for Chapter 11 bankruptcy due to the financial collapse of an Ohio-based health care industry financier that provided the company's hospitals with daily cash. Although GSCH remained open while the hospital's owner filed for bankruptcy protection, the day-to-day operations of the hospital were clearly stressed even with the revenue it received from DC's HealthCare Alliance. Evidence of this was witnessed through repeated failed facility inspections, frequent emergency room staffing and supply shortages, and copious equipment malfunctions. In 2003, the hospital lost its license and was forced to operate under a provisional license.

In 2007, through pressure from the DC Council, the owners of the hospital were forced to sell the operation to Specialty Hospitals of Washington (SHW) which entered the District in 2005. However,

SHW had both weak financials and a questionable operating plan. Thus, the hospital required nearly \$100 million in assistance from the District to repair GSCH's aging infrastructure and address operational issues left by the previous ownership – problems which ultimately resulted in a loss of the hospital's accreditation.

With this infusion of cash, the hospital board decided to rebrand the GSCH as the “United Medical Center” and, with District funds, made numerous infrastructure improvements. This included the addition of a new roof, generators, and the upgrading of critical medical technology, such as radiology equipment. In addition, the Board opened the only hospital-based skilled nursing facility in the District of Columbia while taking steps to review and improve hospital product lines, enhance customer service, and begin a focus on performance improvements. As a result, the hospital was able to regain accreditation.

Despite securing accreditation based on the infusion of cash from the District following the 2007 purchase, UMC struggled to effectively operate as a full-service hospital and, by mid-2009, was on the brink of closure. The litany of problems at the facility included:

- A depleted and aging staff of physicians;
- Shortage of supplies needed to provide routine and emergency care;
- General hospital mismanagement by C-Suite staff;
- Declining patient census; and,
- Hospital losses that were growing by \$1 million per month producing \$20 million in debts.

In 2010, Specialty Hospital defaulted on loan payments due to the city for UMC. In response -- and after deciding against a plan to operate UMC as a receiver -- the District held an auction on the steps of the Wilson Building. However, the sale attracted only one bidder – the District. Thus, the transaction was completed with the District acquiring the assets of the hospital (but not its liabilities) through the forgiving of \$20 million in debt owed by UMC to the City.

After this acquisition, the city named an independent board to oversee its new purchase and provided the hospital with \$26 million in budget authority to support the creation of the Not-for-Profit Hospital Center. When the Council voted for the creation of the city-appointed board to run the hospital, the District was essentially back in the business of owning a struggling hospital for the first time since the 2001 closure of DC General. This raised the troubling specter of future public subsidies to support the operation of another low-performing hospital.

### **C.3.4 Historical Problems of United Medical Center**

Following the city's purchase of UMC, the hospital struggled in its effort to deliver a consistent level of quality care. While UMC was able to retain the accreditation that was lost in 2007 and regained in 2010, the operational and financial problems were numerous and certainly not inconsequential. As a result, when Mayor Vincent Gray was elected to office in 2010, he later directed DHCF to fund an assessment of the sustainability of UMC's business model in light of the changes wrought by healthcare reform and the shifting market forces that worked against the prospects of success for independently-operated public hospitals.

As a part of this review, the Mayor requested an independent assessment of UMC's financial and business operations and liabilities considering both the hospital's payer mix and the nature and amount of the reimbursement it receives from the District of Columbia's Medicaid program.

The review was performed by RSM McGladrey and completed in September 2011. Though the report clearly identified the many improvements that had been made at UMC in the years since the hospital was purchased out of bankruptcy, a number of significant problems were noted. These included:

- An absence of strategic plan to guide the future direction of hospital;
- Reliance on an outdated and expensive business model which emphasizes 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 several million dollars or more;
- Insufficient documentation to support billing and collection processes and a general lack of clarity among financial services staff regarding roles and responsibilities; and,
- Delayed billing collection, increases in patient account receivables, and a strained cash position for the hospital – UMC's January 2012 cash report indicated that the hospital did not have enough funds on hand to meet its monthly obligations.

Based on their assessment, RSM McGladrey recommended a reconfiguration of the acute care hospital to a more "ambulatory and physician-centric" model. The consultants concluded that only 60 general purpose beds were needed with an additional to be determined number for intensive-care, obstetrics, psychiatric, and observation. This, the consultants noted, "was consistent with a national trend away from large inpatient hospitals."

Shortly after the McGladrey report, the UMC Board requested \$15 million from the District to cover operating costs and to fund loan forgiveness. When DHCF later discovered that UMC had been substantially overpaid in previous years by \$17.3 million in Medicaid funds, the financial picture at the hospital was further compromised causing UMC to request another subsidy from the District.

### **C.3.5 The Huron Hospital Turnaround**

The continuing request by UMC for operating subsidies, prompted Mayor Gray to request funds to support a turnaround of the hospital. In February 2013, the Council approved a proposal for a hospital consulting team and awarded a two-year \$12.7 million contract to Huron Consulting. Huron was charged with turning around the fortunes at UMC while seeking a partner for the long-term operation of the facility.

The Contractor's baseline work on UMC confirmed what the hospital's financial statements had suggested. Huron found UMC to be encumbered by serious structural challenges – volume trends were generally negative, patient acuity levels were declining, patient satisfaction was alarmingly low, and the medical staff was inadequate in terms of both the number of doctors and specialty practices represented. Given these findings, it was not surprising that UMC was found to benefit from very little market penetration even by residents in the hospital's Primary Service Area of Wards 7 and 8.

With respect to the patient market in these two Wards, Huron found that it was growing rapidly and aging but not necessarily diversifying. The residents in this Primary Service Area had very high utilization rates for healthcare services – inpatient utilization was 71% higher than normal and patients visited the ER at twice the normal rate. It was instructive to learn, nonetheless, that most of the inpatient admissions and ER visits were not to UMC.

In fact, UMC's market share in the Primary Service Area of Wards 7 and 8 was only 15%. This means that 85% of patients in UMC's Primary Service Area who require hospitalization were leaving the market for hospitals in other areas of the city. More ominous for UMC, even the Medicaid and uninsured patients were discovered to be leaving the Primary Service Area to receive their care elsewhere. And while UMC's share of emergency room business was high, this did not translate into inpatient admissions suggesting that most who visited the hospital did so to address only primary care needs. Meanwhile outpatient services were only a small percentage of UMC's activity.

Huron took over the management of UMC in 2013 and also initiated work on the development of a long-term operating plan for the hospital. Through the deployment of 50 more staff at the hospital, Huron focused, with some success, on instituting a range of operational improvements designed to increase the

bottom line performance of the hospital. At the conclusion of its contract, UMC's growing expenses had been curtailed and the hospital was operating at essentially a break-even position. Still, while the hospital's performance showed improvement on several metrics -- higher patient volume in both admissions and emergency room visits, increased operating revenue, expense reduction -- the position of UMC in the District health care market remained precarious.

Specifically, in FY2016, following the departure of Huron, UMC experienced a double digit increase in hospital expenses. In addition, due to the unexpected impact of changes made by DHCF to its Medicaid's inpatient reimbursement methodology and a loss of Disproportionate Share Hospital funds, the Board for UMC reported that the hospital could not meet its obligations for the fiscal year and requested another \$17 million subsidy from the District

### C.3.6 The Veritas Engagement

In response to this latest emergency, Mayor Muriel Bowser instructed the Director of DHCF to find an operator for the hospital for the purpose of stabilizing hospital operations. DHCF's Director recommended to the Board of Director that it consider hiring Veritas to take over management of UMC. After deliberations, the Board voted unanimously to award a contract to Veritas of one base and two option years.

When Veritas assumed management control of UMC in April 2016 the problems were numerous and ubiquitous:

- *Hospital Finances.* As mentioned, over the 12-months prior to Veritas' engagement in April 2016, the District allocated \$17 million in subsidies to UMC to cover operating deficits and ensure that the hospital could meet payroll. While the previous CEO worked with the Office of the Chief Financial Officer (OCFO) to initiate a 10 percent workforce reduction, the underlying operational problems that drove expenses beyond the hospital's revenue base had to be diagnosed and corrected, including establishing a better system of checks and balances to ensure the departmental funding decisions were not at odds with the hospital's cash-on-hand.
- *Revenue Cycle.* The system of administrative and clinical functions that contribute to the capture of charges, the management of claims processing, and collection of patient service revenue was broken, especially on the front-end of the process. With the departure of Huron's revenue cycle team in February 2015, the bifurcated, disjointed system was returned to its pre-Huron level of dysfunction -- outdated charge master, missing charges, poor claims development, etc. -- resulting in delays in billing and a loss of revenue, further eroding the hospital's cash position.
- *Quality Department.* The department responsible for quality management was a small, isolated, siloed team focused on the basics of reporting, with no attention to hospital-wide performance improvement. As a result, there was no system in place to oversee and improve processes across the hospital and address quality in a collaborative way. Noticeably lacking was a formal quality improvement program needed to establish an environment of care focused on daily patient safety through internal audits, patient rounds, and practices that improve the quality of care. The Director of Quality, the Risk Manager, and the Patient Advocate/Patient Experience positions were vacant.
- *Hospital Accreditation.* There was no formal, hospital-wide plan in place to prepare for the upcoming Joint Commission Accreditation, which has recently shifted to a more rigorous survey process that is tightly focused on patient safety. The key staff person responsible for

this function walked away from the hospital in a sudden departure, and the existing staff evinced only a limited understanding of the standards and elements of performance required to successfully complete the survey process, ensure patient safety, and protect UMC's accreditation.

- *Emergency Department Operations.* Like many service lines, the emergency department experienced high turnover, while operations suffered from the absence and routine application of established clinical protocols that have the potential to expedite the effective delivery of care. The ED nursing leader position was vacant.
- *Physician Services.* Apart from a severely limited range of specialty services, the hospital physicians operated with few if any quality metrics in their contracts. Likewise, the physicians did not, as a rule, adhere to standards for clinical documentation of patient care, undermining UMC's capacity to effectively bill for services provided. The hospitalists were permitted to maintain full physician practices outside of their hospital duties and were individually responsible for more patients than the national average of 15-18 patients. As a result, timeliness and cost-effectiveness of care were negatively impacted.
- *Nurse Staffing and Recruiting.* There was a nursing turnover issue at the hospital and the nursing collective bargaining agreement expired Jan. 7, 2013 (more than 3 years prior to Veritas' arrival). Filling nursing positions in DC is a challenge due to the substantial number of nurse job openings per capita and DC having one of the lowest annual nursing salaries in the country (adjusted for cost of living).
- *Compliance.* The position responsible for compliance was vacant and weighty issues raised in a 2015 audit report found that material weaknesses in the hospital were not being addressed.

### **C.3.7 Performance Improvements by Veritas**

In the 17-month period covering Veritas' engagement at UMC they have executed a number of activities to address the problems at UMC. Included among the initiatives are the following:

- *Assessment and Development of Management Plan.* Following the completion of an environmental scan of the hospital, Veritas developed a management action plan for FY2017 that included metrics which were used to gauge hospital performance and guide the day-to-day work of the operator.
- *Accreditation.* Established a team of experts to prepare the hospital for a rigorous accreditation review by the Joint Commission. This team instituted programs to address operational deficiencies that might jeopardize accreditation and successfully passed the Joint Commission on-site survey on September 22, 2017 with only a 1.2% deficiency rate, maintaining the hospital's accreditation.
- *Patient Quality.*
  - Hired Quality Department leadership to evaluate, design, and deploy a framework for continuous quality improvement and patient safety. Established relationships and negotiated contracts with three nursing agencies.
  - Established front end clinical protocols -- expedite lab work, x-rays / radiology, medication, etc. -- to improve patient throughput and reduce disposition time prior to seeing physicians.

- Hired additional leaders at multiple management levels within the ED to improve staff utilization and oversight.
- Actively supported the development of an innovative nurse recruiting program with educational institutions from the Island of Puerto Rico to recruit experienced nurses.
- Implemented electronic scheduling of staff.
- *Improving Physician Services.*
  - Hired new Assistant Director for Medical / Surgical nursing
  - Aligned nurse to patient ratios with national standards
  - Established hourly nurse rounding to improve patient care (visiting with patients)
  - Created a platform for nurse staff to participate in day-to-day clinical practice
  - Recruited and hired 2 GI physicians, an urologist, and contracted with an orthopedic group.
  - Recruited and hired two family medicine physicians and one internal medicine physician.
  - Implemented a formal diabetic program to educate all diabetics inpatient. The program also monitors medication management and nutritional counseling.
  - Negotiated quality metrics into option year extensions of existing agreements for medical services.
  - Executed a major procurement to secure physicians for largest departments in the hospital – Emergency and Hospitalist (inpatient care) – both of which have been awarded to George Washington Medical Faculty Associates and will soon be before the Board for final consideration. If approved, the contracts will take effect in early 2018.

After 18 months in UMC, on November 7, 2017, the Council, by a vote of 7-6, terminated the Veritas contract that the UMC Board of Directors (Board) unanimously approved in February 2016. Thus, effective December 1, 2017, this disapproval action proscribes the Board from executing the first option year of the Veritas contract which was valued at \$3.6 million with additional allowances for employee expenses that averaged just over \$8,000 per month in the first year of the contract.

As a result, the District is executing this RFP to secure the services of a replacement operator. To ensure an effective transition, the Board of Directors has extended the contract of Veritas for up to 60 days.

### C.3.6 Current Profile & Key Stakeholders

#### Services Offered – as of Nov 2017

Clinical	<ul style="list-style-type: none"> <li>• Inpatient Medical and Surgical</li> <li>• Inpatient surgery (general/medical, orthopedics, vascular, urology, gastroenterology)</li> <li>• Skilled Nursing unit</li> <li>• Emergency Services</li> <li>• Inpatient behavioral health</li> <li>• Community/Population Health</li> </ul>
Ambulatory	<ul style="list-style-type: none"> <li>• Comprehensive wound care including hyperbaric therapy</li> <li>• Outpatient provider clinics for primary care, orthopedics, gynecology, cardiology, infectious disease, general surgery, urology, gastroenterology)</li> </ul>
Ancillary	<ul style="list-style-type: none"> <li>• Same day and outpatient surgery (same specialties as above in “clinical”) Comprehensive Radiology and Imaging</li> <li>• Endoscopy</li> </ul>

	<ul style="list-style-type: none"> <li>• Interventional radiology / cardiology</li> <li>• Mobile health services</li> <li>• Physical Rehabilitation (PT, OT, ST)</li> <li>• Clinical Laboratory (blood bank, microbiology, chemistry, hematology) Respiratory Services</li> <li>• Sleep Center</li> <li>• Inpatient renal dialysis</li> <li>• Inpatient and outpatient diabetic education</li> <li>• Occupational Health</li> </ul>
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**Key Hospital Statistics**

Patient Days	3027 - 3662 per month
Average Daily Census (including Observation)	107-116 per month
Admissions	550-628 per month
Medicare CMI - July	1.794
DC Medicaid CMI - July	1.192
Average Length of Stay	5.6 – 6.4

**Hospital Stakeholders.**

The Hospital and all of its programs and services have a number of important stakeholders, including, but not limited to:

- District of Columbia residents
- Hospital Board of Directors
- Hospital Staff
- Hospital Medical Staff
- Hospital Management
- Mayor of the District of Columbia
- Council of the District of Columbia
- DC Department of Health Care Finance
- DC Department of Health
- DC Office of the Chief Financial Officer

**C.5 REQUIREMENTS**

**C.5.1** The Contractor shall conduct an assessment of Hospital operations and develop a management action plan for the Board of Directors that reflects a strategy to operate within the projected revenues of the Hospital.

**C.5.2** The Contractor shall assess adequacy of Hospital Organizational Structure to achieve and sustain necessary performance improvements and implement required personnel changes to improve Hospital operations.

**C.5.3** The Contractor shall work with the Office of the Chief Financial Officer to improve revenue cycle, cash flow management and accounts receivable operations.

**C.5.4** The Contractor shall submit quarterly progress reports with performance against metrics to the Board of Directors.

- C.5.5** The Contractor shall conduct a thorough review of program development with the goal of aligning physicians, nurses and staff around healthcare services to produce best outcomes.
- C.5.5.1** The Contractor shall conduct a thorough review of clinical policies and practices with a goal of aligning with best practice standards, ensuring adequate staff and vendor training, reducing the severity and frequency of poor quality outcomes, and improving the overall patient experience.
- C.5.6** The Contractor shall pursue cost savings through both clinical and operations performance improvements, including updates to Hospital MCO contracts.
- C.5.7** The Contractor shall conduct a labor analysis and review budgeted staffing and structure to determine appropriate use of resource to ensure optimal use of staff to achieve improvements in efficiency, as well as patient and staff satisfaction.
- C.5.8** Analyze key operating metrics, including:
- C.5.8.1** Patient Admissions
  - C.5.8.2** Discharges
  - C.5.8.3** Adjusted patient days
  - C.5.8.4** Adjusted man hours per patient day
  - C.5.8.5** Outpatient visits
  - C.5.8.6** Average length of stay
  - C.5.8.7** CMI
  - C.5.8.8** Percentage of surgical admissions and occupancy levels
- C.5.9** Based on the results provided above, the Contractor shall develop and implement rational staffing recommendations for staff and management throughout the organization.
- C.5.10** The Contractor shall conduct a detailed review and analysis of contracting and supply chain to identify areas where change in process or purchasing agreements will yield meaningful savings, focusing on the following:
- C.5.10.1** Materials management policies, procedures and work flow.
  - C.5.10.2** Supply and resource utilization with a focus on high cost and high-volume areas.
  - C.5.10.3** Pricing analysis with a focus on high cost and high-volume areas.
  - C.5.10.4** Review of purchased service agreements and relevant supply agreements.
  - C.5.10.5** Opportunity for more centralized supply chain functions.
  - C.5.10.6** Standardization of medical and surgical supplies to drive down cost.
  - C.5.10.7** Utilization of contract database to assist with contract administration
  - C.5.10.8** Review all contracts for goods and services for cost-savings, efficiencies, and compliance with applicable federal and local laws and regulations, including Stark and AKS.
  - C.5.10.9** Perform necessary trainings to ensure competency in hospital and government contracting, especially for those with official contracting duties i.e. COTR, CO.
- C.5.11** The Contractor shall evaluate the performance of the newly hired emergency department, hospitalists, and intensivists, in delivering quality care while filling the historical gaps in physician specialties.
- C.5.12** The Contractor shall identify and make recommendations for IT improvements Hospital wide.
- C.5.13** The Contractor shall participate in Council/Stakeholder hearings and meetings.

**SECTIONS D and E intentionally deleted.**

**SECTION F: PERIOD OF PERFORMANCE AND DELIVERABLES**

**F.1 TERM OF CONTRACT**

The term of the contract shall be for a period of eight (8) months from date of award specified on the cover page of this contract.

**F.2 OPTION TO EXTEND THE TERM OF THE CONTRACT**

**F.2.1** The RFP Issuer may extend the term of this contract for a period of two (2) one-year Option Periods, or successive fractions thereof, by written notice to the Contractor before the expiration of the contract; provided that the RFP Issuer will give the Contractor preliminary written notice of its intent to extend at least thirty (30) days before the contract expires. The preliminary notice does not commit the RFP Issuer to an extension. The exercise of this option is subject to the availability of funds at the time of the exercise of this option. The Contractor may waive the thirty (30) day preliminary notice requirement by providing a written waiver to the Contracting Officer prior to expiration of the contract.

**F.2.2** If the RFP Issuer exercises this option, the extended contract shall be considered to include this option provision.

**F.2.3** The price for the option period shall be as specified in the Section B of the contract.

**F.2.4** The total duration of this contract, including the exercise of any options under this clause, shall not exceed two (2) years and eight (8) months.

**F.3 DELIVERABLES**

The Contractor shall perform the activities required to successfully complete the RFP Issuer's requirements and submit each deliverable to the Contract Administrator (CA) and the Board of Directors identified in section G.9 in accordance with the following:

<b>CLIN</b>	<b>Deliverable</b>	<b>Quantity</b>	<b>Format/Method of Delivery</b>	<b>Due Date</b>
1	Management Action Plan	1	PowerPoint Briefing	TBD
2	Hospital Organization Plan	1	PowerPoint Briefing	TBD
3	Revenue Cycle Report	1	PowerPoint Briefing	TBD
4	Clinical Process & Quality Improvement Plan	1	PowerPoint Briefing	TBD
5	Labor Analysis Plan	1	PowerPoint Briefing	TBD
6	Supply Chain Plan & Contracts Plan	1	PowerPoint Briefing	TBD
7	Report on Performance of Emergency Department, Hospitalists, Intensivists	1	Powerpoint Briefing	Quarterly
8	IT Analysis	1	PowerPoint Briefing	TBD

## **SECTION G: CONTRACT ADMINISTRATION**

### **G.1 INVOICE PAYMENT**

**G.1.1** The District will make payments to the Contractor, upon the submission of proper invoices, at the prices stipulated in this contract, for supplies delivered and accepted or services performed and accepted, less any discounts, allowances or adjustments provided for in this contract.

**G.1.2** The District will pay the Contractor on or before the 30<sup>th</sup> day after receiving a proper invoice from the Contractor.

### **G.2 INVOICE SUBMITTAL**

**G.2.1** The Contractor shall submit proper invoices on a monthly basis electronically to the Contract Administrator at [dhcf.invoices@dc.gov](mailto:dhcf.invoices@dc.gov) and by mail at:

Office of the Chief Financial Officer  
Human Support Services Cluster  
Accounts Payable Department  
64 New York Avenue, 4<sup>th</sup> Floor  
Washington, DC 20002

**G.2.2** To constitute a proper invoice, the Contractor shall submit the following information on the invoice:

**G.2.2.1** Contractor's name, federal tax ID and invoice date (date invoices as of the date of mailing or transmittal);

**G.2.2.2** Contract number and invoice number;

**G.2.2.3** Description, price, quantity and the date(s) that the supplies or services were delivered or performed;

**G.2.2.4** Other supporting documentation or information, as required by the Contracting Officer;

**G.2.2.5** Name, title, telephone number and complete mailing address of the responsible official to whom payment is to be sent;

**G.2.2.6** Name, title, phone number of person preparing the invoice;

**G.2.2.7** Name, title, phone number and mailing address of person (if different from the person identified in G.2.2.6 above) to be notified in the event of a defective invoice; and

**G.2.2.8** Authorized signature.

### **G.7 CONTRACTING OFFICER (CO)**

Contracts will be entered into and signed on behalf of the Hospital only by Hospital contracting officers. The contact information for the Contracting Officer is:

Cynthia Mann  
Project Manager/Contracting Officer

United Medical Center  
1310 Southern Avenue SE  
Washington, DC 20032  
[cmann@united-medicalcenter.com](mailto:cmann@united-medicalcenter.com)  
202-574-6088

## **G.8 AUTHORIZED CHANGES BY THE CONTRACTING OFFICER**

**G.8.1** The CO is the only person authorized to approve changes in any of the requirements of this contract.

**G.8.2** The Contractor shall not comply with any order, directive or request that changes or modifies the requirements of this contract, unless issued in writing and signed by the CO.

**G.8.3** In the event the Contractor effects any change at the instruction or request of any person other than the CO, the change will be considered to have been made without authority and no adjustment will be made in the contract price to cover any cost increase incurred as a result thereof.

## **G.9 CONTRACT ADMINSTRATOR (CA)**

**G.9.1** The CA is responsible for general administration of the contract and advising the CO as to the Contractor's compliance or noncompliance with the contract. The CA has the responsibility of ensuring the work conforms to the requirements of the contract and such other responsibilities and authorities as may be specified in the contract. These include:

**G.9.1.1** Keeping the CO fully informed of any technical or contractual difficulties encountered during the performance period and advising the CO of any potential problem areas under the contract;

**G.9.1.2** Coordinating site entry for Contractor personnel, if applicable;

**G.9.1.3** Reviewing invoices for completed work and recommending approval by the CO if the Contractor's costs are consistent with the negotiated amounts and progress is satisfactory and commensurate with the rate of expenditure;

**G.9.1.4** Reviewing and approving invoices for deliverables to ensure receipt of goods and services. This includes the timely processing of invoices and vouchers in accordance with the District's payment provisions; and

**G.9.1.5** Maintaining a file that includes all contract correspondence, modifications, records of inspections (site, data, equipment) and invoice or vouchers.

**G.9.2** The address and telephone number of the CA is:

Kai Blissett  
Special Assistant to the Director  
DC Department of Health Care Finance  
441 4<sup>th</sup> St. NW  
Suite 900S  
Washington, DC 20001  
(202) 442 - 8994  
[Kai.Blissett@dc.gov](mailto:Kai.Blissett@dc.gov)

**G.9.3** The CA shall NOT have the authority to:

1. Award, agree to, or sign any contract, delivery order or task order. Only the CO shall make contractual agreements, commitments or modifications;
2. Grant deviations from or waive any of the terms and conditions of the contract;
3. Increase the dollar limit of the contract or authorize work beyond the dollar limit of the contract,
4. Authorize the expenditure of funds by the Contractor;
5. Change the period of performance; or
6. Authorize the use of District property, except as specified under the contract.

**G.9.4** The Contractor will be fully responsible for any changes not authorized in advance, in writing, by the CO; may be denied compensation or other relief for any additional work performed that is not so authorized; and may also be required, at no additional cost to the District, to take all corrective action necessitated by reason of the unauthorized changes.

**SECTION H – INTENTIONALLY DELETED**

**SECTION I – INTENTIONALLY DELETED**

**SECTION J: ATTACHMENTS & APPLICABLE DOCUMENTS**

The following list of attachments is incorporated into the solicitation by reference.

<b>Attachment Number</b>	<b>Document</b>
<b>J.1</b>	Not-For-Profit-Hospital Corporation – Standard Contract Provision for Use with the Supplies and Services Contracts (December 2010) available at <a href="http://united-medicalcenter.com/about-us/doing-business-with-umc.html">http://united-medicalcenter.com/about-us/doing-business-with-umc.html</a>
<b>J.2</b>	U.S. Department of Labor Wage Determination 2015-4281, Revision 7, dated 7/25/2017
<b>J.3</b>	Equal Employment Opportunity Employer Information Report and Mayor’s Order 85-85 available at available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.4</b>	Department of Employment Services First Source Employment Agreement available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.5</b>	Way to Work Amendment Act of 2006 - Living Wage Notice available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.6</b>	Way to Work Amendment Act of 2006 - Living Wage Fact Sheet available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.7</b>	Tax Certification Affidavit available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.8</b>	Subcontracting Plan (if required by law) available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.9</b>	First Source Initial Employment Plan (if contract is \$300,000 or more) available at <a href="http://ocp.dc.gov">http://ocp.dc.gov</a> , under Quick Links click on “Required Solicitation Documents”
<b>J.10</b>	RSM McCladrey Report. <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.11</b>	Huron Strategic Plan (“Transformation Initiative”) <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.12</b>	Veritas Management Action Plan <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.13</b>	DHCF Presentation to the Hospital Board <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.14</b>	OCFO – DHCF Financial Performance Oversight Reports <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>

<b>J.15</b>	FY 18 Hospital Budget <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.16</b>	October 2017 Testimony of Interim CEO to Council – Committee on Health <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.17</b>	November 2017 Hospital Board Chair Remarks <a href="https://dhcf.dc.gov/">https://dhcf.dc.gov/</a>
<b>J.18</b>	Appendix I Attached with solicitation, and must be completed and submitted with all proposals
<b>J.19</b>	Appendix II Healthcare Customer References Attached with solicitation, and must be completed and submitted with all proposals
<b>J.20</b>	Appendix III Acknowledgement of Required Documentation Attached with solicitation, and must be completed with all proposals
<b>J.21</b>	Attachment A - Schedule of Values Attached with solicitation, and must be submitted with all proposals

## **SECTION L: INSTRUCTIONS, CONDITIONS, CONTRACT CLAUSES, AND NOTICES TO OFFERORS**

### **L.1 Contract Award**

- L.1.1** Most Advantageous: Should the RFP Issuer award a Contract as a result of this RFP process, the award would be to the responsible Firm whose offer will be most advantageous to the RFP Issuer considering cost or price, technical and other factors as specified in this RFP.
- L.1.2** Initial Offers: Should the RFP Issuer award a Contract as a result of this RFP process, the RFP Issuer may do so on the basis of initial offers/proposals received, without discussion. Therefore, each initial proposal should contain the Firms' best terms from a standpoint of cost or price, technical and other factors.
- L.1.3** Contract Provisions: In addition to the Standard Contract Provisions referenced in APPENDIX 3 of this RFP, all Hospital contracts include the following language:
  - L.1.3.1.** ANTI-DEFICIENCY ACTS. The Contract shall be interpreted in accordance with and pursuant to the provisions of (i) the federal Anti-Deficiency Act, 31 U.S.C. §§ 1341, 1342, 1349-1351 1511-1519 (2008) (the "Federal ADA"), and D.C. Official Code §§ 1-206.03(e) and 47-105; (ii) the District of Columbia Anti-Deficiency Act, D.C. Official Code §§ 47-355.01 – 355.08 (the "D.C. ADA"); (iii) Section 446 of the District of Columbia Home Rule Act, D.C. Official Code § 1-204.46 (collectively, as amended from time to time, the "Anti-Deficiency Acts"). Under the Anti-Deficiency Acts the Not for Profit Hospital Corporation ("Hospital") cannot obligate itself to any financial commitment in any present or future year unless the necessary funds to pay that commitment have been appropriated by the Congress of the United States (the "Congress") and are lawfully available for the purpose committed. Thus, pursuant to the Anti-Deficiency Acts, nothing in this Contract shall create an obligation of the Hospital in anticipation of an appropriation by Congress for such purpose, and the Hospital's legal liability for the payment of any amount under this Contract does not and may not arise or obtain in advance of the lawful availability of appropriated funds for the applicable fiscal year as approved by Congress. Any Contract provision that violates the Anti-Deficiency Acts is void; however, the Contract shall remain valid. See section 3 of the Standard Contract Provisions for use with the Not-for Profit Hospital Corporation Supplies and Services Contracts, dated December 27, 2010.
  - L.1.3.2** Indemnity Provisions. The RFP Issuer cannot and does not agree to contract provisions that provide for the RFP Issuer to indemnify the contractor, its agents, employees, invitees, successors, or assigns.
  - L.1.3.3** Contingent Fees. The RFP Issuer cannot and does not agree to enter into contingent fee contracts, unless the fee amount is limited to a specified amount adequately covered by an available appropriation at the time of contact award.
  - L.1.3.4** Contracts in excess of One Million Dollars or Multiyear Contracts. Any contract that provides for expenditures in excess of \$1,000,000 in a twelve (12) month period or any contract which is a Multiyear contract shall not be binding or give rise to any claim or demand against the RFP Issuer until approved by the Council of the District of Columbia and signed by the Contracting Officer.
  - L.1.3.5** Fiscal Year Funds. Contracts that extend beyond the fiscal year are subject to the appropriation of funds.
  - L.1.3.6** Freedom of Information Act. The District of Columbia Freedom of Information Act, at D.C. Official Code §2-532 (a-3), requires the RFP Issuer to make available for inspection and copying any record produced or collected pursuant to a RFP Issuer contract with a private contractor to perform a public function, to the same extent as if the record were maintained by the agency on whose behalf the contract is made.

**L.1.4** Laws applicable to the Hospital include:

**L.1.4.1** District of Columbia Quick Payment Act of 1984, as amended, D.C. Code § 2-221.01; Living Wage Act of 2006, as amended, D.C. Code § 2-220.01; Small, Local, and Disadvantaged Business Enterprise Development and Assistance Act of 2005, as amended, D.C. Code § 2-218.01 and 2-218.50; First Source Employment Agreement Act of 1984, as amended, D.C. Code § 2-219.01; Service Contract Act, 41 USC 351(a); Health Insurance Portability and Accountability Act of 1996, P.L. 104-191; the Privacy and Security Rules codified at 45 C.F.R. Parts 160 and 164.

**L.1.4.2** Applicable Hospital laws, rules and policies, including the Not-for-Profit Hospital Corporation Establishment Act (D.C. Official Code §§44-951.01 *et seq.*, 44-407(b)(14), 2011 Supp.) and the Hospital's Procurement Rules (27 DCMR 46; May 27, 2011).

**L.1.4.3** All other applicable District of Columbia and federal laws and regulations, including laws and regulations of any agency having jurisdiction, including Center for Medicare and Medicaid Services and The District of Columbia.

**L.2 PROPOSAL ORGANIZATION AND CONTENT**

**L.2.4** Offerors are directed to the specific proposal evaluation criteria found in Section M of this solicitation, Evaluation Factors. The offeror shall respond to each factor in a way that will allow the RFP Issuer to evaluate the offeror's response. The offeror shall submit information in a clear, concise, factual and logical manner providing a comprehensive description of program supplies and services and delivery thereof. The information requested for the technical proposal shall facilitate evaluation for all proposals.

**L.2.5** The technical proposal must contain sufficient detail to provide a clear and concise response fully reflecting the manner in which the offeror proposes to fully meet the requirements in Section C.

**L.2.6** Offerors shall complete, sign and submit all Representations, Certifications and Acknowledgments as appropriate.

**L.2.7** The RFP Issuer will reject any offer that fails to include a subcontracting plan that is required by law.

**L.2.8 Technical Proposal – Volume I**

**L.2.8.1** Failure to comply with these instructions may disqualify the vendor from further consideration:

**L.2.8.1.1** Proposal Contents – Each Contractor must demonstrate part and present ability to fulfill the requirements established by this RFP. Each Contractor must also provide detailed information demonstrating its ability to perform the necessary services with specific reference to the requirements in the Scope of Work. Every proposal must be in writing and must include but may not be limited to:

**L.2.8.1.1.1** Cover Letter: Provide a brief description of the Contractor or individual, name, title, address, telephone number, and e-mail of principal contact person.

**L.2.8.1.1.2** Executive Summary: One page summary of the Contractor's proposal (technical & financial), which must succinctly convey the Contractor's understanding of the RFP's scope.

**L.2.8.1.1.3 Relevant Experience and References:** The RFP Issuer wishes to engage a Contractor with the experience necessary to realize the goal and successfully complete the required work as described herein. Complete Appendix 1.

**L.2.8.1.1.4 Project Management Plan**

**L.2.8.1.1.5 Key Personnel:** Offerors shall assign personnel to this Project with experience in fulfilling similar scopes of work.

**L.2.8.1.1.6 Proposed Pricing Schedule:** The Contractor should respond in the format provided in Attachment A to this RFP listing every cost that is being proposed with a capped annual dollar amount for each cost. Include the following information:

**L.2.8.1.1.6.1** What is your proposed financial arrangement?

**L.2.8.1.1.6.2** Identify your current professional liability insurance company and the amount of coverage you carry.

**L.2.8.1.1.7** The Contractor should not any parts of any Scope of Work that is beyond the expertise of the Contractor.

## **L.2.8.2 Acceptance of Proposals**

The submission of a proposal pursuant to this RFP shall constitute acknowledgement and acceptance of all terms and conditions set forth herein.

- Proposals should be prepared simply and economically, avoiding the use of unnecessary promotional material. The RFP Issuer will not reimburse costs of preparing such proposals.
- No member of the Hospital's Board of Directors or its Executive Staff shall have a financial interest in any Contractor's proposal.
- In cases of disputes over differences of opinions as to the services in the proposal, the decision of the RFP Issuer Hospital shall be final.
- Contractors agree that, as a condition of submitting a Proposal to this RFP, it will review the Hospital's Standard Contract Provisions with the understanding that no changes may be made to these or any other of the Additional Documentation required by the RFP Issuer, except as may be decided by the RFP Issuer in its sole and absolute discretion.
- The RFP Issuer reserves the right to ask any Contractor for clarification of their proposal should the need arise.
- This RFP and any resulting proposal, or any part of either the RFP or the Contractor's proposal, may be incorporated into and made part of any contract awarded as a result of this RFP. The RFP Issuer reserves the right to further negotiate stated terms and conditions with the selected Contractor. As provided for in the Hospital's Procurement Rules, the RFP Issuer reserves the right to cancel this RFP at any time, to reject all proposals, reject any proposal for non-compliance with RFP provisions, and/or to choose not to award a contract if such action is determined to be in the best interest of the RFP Issuer. The successful offeror will be required to comply with the Department of Labor Wage Determination attached to this RFP.
- The RFP Issuer reserves the right to accept or reject any sub-contractor, franchisee, or business partner through which any goods or services will be offered pursuant to any Contractors'

proposal. Any such deliverables by such third parties whether provided directly or indirectly must be clearly identified in the Contractor's proposal along with a detailed description of the goods or services to be provided.

- All proposals submitted shall be held for a period of 120 days after the submission is received by the RFP Issuer.
- Bonding – The successful Contractor will be required to provide a cost for the performance and payment bond for the entire Project. The costs for this bond should not be included within the Stipulated Sum but identified as a separate cost.

### **L.2.8.3 Presentations**

If invited for an in-person presentation following the proper submission of a proposal, a Contractor's presentation should be limited to 30 minutes in duration unless the RFP Issuer approves otherwise, and each presentation will be followed by questions.

## **L.3 REQUIREMENT FOR AN ELECTRONIC COPY OF PROPOSALS TO BE MADE AVAILABLE TO THE PUBLIC**

In addition to the proposal submission requirements in Section L above, the offeror must submit an electronic copy of its proposal, redacted in accordance with any applicable exemptions from disclosure under D.C. Official Code § 2-534. Redacted copies of the offeror's proposal must be submitted by email attachment to the contact person designated in the solicitation. D.C. Official Code § 2-536(b) requires the RFP Issuer to make available electronically copies of records that must be made public. The RFP Issuer's policy is to release documents relating to RFP Issuer proposals following award of the contract, subject to applicable Freedom of Information Act (FOIA) exemption under § 2-534(a)(1).

## **L.4 PROPOSAL SUBMISSION DATE AND TIME, AND LATE SUBMISSIONS, LATE MODIFICATIONS, WITHDRAWAL OR MODIFICATION OF PROPOSALS AND LATE PROPOSALS**

**L.4.1** Respondents must submit their proposals in paper & electronically no later than **12:00 noon on December 12, 2017.**

**L.4.2 Electronic:** All attachments shall be submitted as a .pdf file. RFP Issuer will not be responsible for corruption of any file submitted. If the submitted file cannot be viewed and printed as submitted, it will not be considered.

**L.4.2.1** The offeror shall submit two (2) attachments in its electronic submittal: (1) a technical proposal, and (2) a price proposal. **Please note that each attachment is limited to a maximum size of 25 MB. Proposals shall be delivered to the following:**

Kenneth Evans  
Chief Operating Officer and Deputy Chief of Staff  
Department of Health Care Finance  
441 4<sup>th</sup> St. NW., Suite 900S  
Washington, DC 20001

**L.4.2.2** The offeror shall label each attachment, i.e., "Technical Proposal", "Price Proposal."

**L.4.3 Two (2) original paper copies** of the proposal must be sent to the RFP Proposal Delivery Address set forth on the Solicitation Offer and Award page in a sealed package clearly marked with the proposal title including the RFP # and the Respondent's name, address, phone number and email. Electronic copies must be sent in PDF format and must be sent to only the RFP Coordinator. Email submissions are NOT in lieu of paper copy submissions and email submissions will be deemed UNRESPONSIVE if paper or electronic copy is not received by the deadline

**L.4.4 Withdrawal or Modification of Proposals**

An offeror may modify or withdraw its proposal at any time before the closing date and time for receipt of proposals.

**L.4.5 Late Proposals**

The RFP Issuer will not accept late proposals or modifications to proposals after the closing date and time for receipt of proposals.

**L.4.6 Late Modifications**

A late modification of a successful proposal, which makes its terms more favorable to the RFP Issuer, shall be considered at any time it is received and may be accepted.

**L.5 EXPLANATION TO PROSPECTIVE OFFERORS**

If a prospective offeror has any questions relating to this solicitation, the prospective offeror shall submit the question electronically to Chief Operating Officer and Deputy Chief of Staff, Kenneth Evans, upon request. The RFP Issuer will furnish responses electronically. An amendment to the solicitation will be issued if the RFP Issuer decides that information is necessary in submitting offers, or if the lack of it would be prejudicial to any prospective offeror. Oral explanations or instructions given by RFP Issuer before the award of the contract will not be binding.

**L.6 RESTRICTION ON DISCLOSURE AND USE OF DATA**

**L.6.1** Offerors who include in their proposal data that they do not want disclosed to the public or used by RFP Issuer except for use in the procurement process shall mark the title page with the following legend:

**"This proposal includes data that shall not be disclosed outside the District and Hospital, and shall not be duplicated, used or disclosed in whole or in part for any purpose except for use in the procurement process. If, however, a contract is awarded to this offeror as a result of or in connection with the submission of this data, the District and Hospital will have the right to duplicate, use, or disclose the data to the extent consistent with the District's needs in the procurement process. This restriction does not limit the District's or Hospital's rights to use, without restriction, information contained in this proposal if it is obtained from another source. The data subject to this restriction are contained in sheets (insert page numbers or other identification of sheets)."**

**L.6.2** Mark each sheet of data it wishes to restrict with the following legend:

**"Use or disclosure of data contained on this sheet is subject to the restriction on the title page of this proposal."**

**L.7 PROPOSALS WITH OPTION YEARS**

The offeror shall include option year prices in its price/cost proposal. An offer may be determined to be unacceptable if it fails to include pricing for the option year(s).

#### **L.8 PROPOSAL PROTESTS**

All protests shall comply with the Not-for-Profit Hospital Corporation's Procurement Rules, 27 DCMR 46. <https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=27-46>

#### **L.9 UNNECESSARILY ELABORATE PROPOSALS**

Unnecessarily elaborate brochures or other presentations beyond those sufficient to present a complete and effective response to this solicitation are not desired and may be construed as an indication of the offeror's lack of cost consciousness. Elaborate artwork, expensive visual and other presentation aids are neither necessary nor desired.

#### **L.10 RETENTION OF PROPOSALS**

All proposal documents will be the property of the RFP Issuer and retained by the RFP Issuer, and therefore will not be returned to the offerors.

#### **L.11 PROPOSAL COSTS**

The District and Hospital are not liable for any costs incurred by the offerors in submitting proposals in response to this solicitation.

#### **L.12 CERTIFICATES OF INSURANCE**

Prior to commencing work, the Contractor shall have its insurance broker or insurance company submit certificates of insurance giving evidence of the required coverages as specified in Section I.8 to:

Kenneth Evans  
Chief Operating Officer and Deputy Chief of Staff  
Department of Health Care Finance  
441 4<sup>th</sup> St. NW., Suite 900S  
Washington, DC 20001

#### **L.13 ACKNOWLEDGMENT OF AMENDMENTS**

The offeror shall acknowledge receipt of any amendment to this solicitation electronically. The RFP Issuer must receive the acknowledgment by the date and time specified for receipt of proposals. An offeror's failure to acknowledge an amendment may result in rejection of its offer.

#### **L.14 BEST AND FINAL OFFERS**

See Not-for-Profit Hospital Corporation's Procurement Rules, 27 DCMR 46. <https://www.dcregs.dc.gov/Common/DCMR/RuleList.aspx?ChapterNum=27-46>

#### **L.15 LEGAL STATUS OF OFFEROR**

Each proposal must provide the following information:

**L.15.1** Name, address, telephone number and federal tax identification number of offeror;

**L.15.2** A copy of each District of Columbia license, registration or certification that the offeror is required by law to obtain. If the offeror is a corporation or partnership and does not provide a copy of its license, registration or certification to transact business in the District of Columbia, the offer shall certify its intent to obtain the necessary license, registration or certification prior to contract award or its exemption from such requirements; and

**L.15.3** If the offeror is a partnership or joint venture, the names and addresses of the general partners or individual members of the joint venture, and copies of any joint venture or teaming agreements.

## **L.16 FAMILIARIZATION WITH CONDITIONS**

Offerors shall thoroughly familiarize themselves with the terms and conditions of this solicitation, acquainting themselves with all available information regarding difficulties which may be encountered, and the conditions under which the work is to be accomplished. Contractors will not be relieved from assuming all responsibility for properly estimating the difficulties and the cost of performing the services required herein due to their failure to investigate the conditions or to become acquainted with all information, schedules and liability concerning the services to be performed.

## **L.17 GENERAL STANDARDS OF RESPONSIBILITY**

The prospective contractor must demonstrate to the satisfaction of the RFP Issuer its capability in all respects to perform fully the contract requirements; therefore, the prospective contractor must submit relevant documentation within five (5) days of the request by the RFP Issuer.

**L.17.1** To be determined responsible, a prospective contractor must demonstrate that it:

- (a) Has adequate financial resources, or the ability to obtain such resources, required to perform the contract;
- (b) Is able to comply with the required or proposed delivery or performance schedule, taking into consideration all existing commercial and government contract commitments;
- (c) Has a satisfactory performance record;
- (d) Has a satisfactory record of integrity and business ethics;
- (e) Has a satisfactory record of compliance with the applicable District licensing and tax laws and regulations;
- (f) Has, or has the ability to obtain, the necessary organization, experience, accounting, and operational control, and technical skills;
- (g) Has, or has the ability to obtain, the necessary production, construction, technical equipment, and facilities;
- (h) Has not exhibited a pattern of overcharging the RFP Issuer;
- (i) Does not have an outstanding debt with the RFP Issuer or the federal government in a delinquent status; and
- (j) Is otherwise qualified and is eligible to receive an award under applicable laws and regulations.

**L.17.2** If the prospective contractor fails to supply the information requested, the RFP Issuer shall make the determination of responsibility or non-responsibility based upon available information. If the available information is insufficient to make a determination of responsibility, the CO shall determine the prospective contractor to be non-responsible.

## SECTION M - EVALUATION FACTORS

### M.1 EVALUATION FOR AWARD

The contract will be awarded to the responsible offeror whose offer is most advantageous to the RFP Issuer, based upon the evaluation criteria specified below. Thus, while the points in the evaluation criteria indicate their relative importance, the total scores will not necessarily be determinative of the award. Rather, the total scores will guide the RFP Issuer in making an intelligent award decision based upon the evaluation criteria.

### M.2 TECHNICAL RATING

#### M.2.1 The Technical Rating Scale is as follows:

<u>Numeric Rating</u>	<u>Adjective</u>	<u>Description</u>
0	Unacceptable	Fails to meet minimum requirements; e.g., no demonstrated capacity, major deficiencies which are not correctable; offeror did not address the factor.
1	Poor	Marginally meets minimum requirements; major deficiencies which may be correctable.
2	Minimally Acceptable	Marginally meets minimum requirements; minor deficiencies which may be correctable.
3	Acceptable	Meets requirements; no deficiencies.
4	Good	Meets requirements and exceeds some requirements; no deficiencies.
5	Excellent	Exceeds most, if not all requirements; no deficiencies.

**M.2.2** The technical rating is a weighting mechanism that will be applied to the point value for each evaluation factor to determine the offeror's score for each factor. The offeror's total technical score will be determined by adding the offeror's score in each evaluation factor. For example, if an evaluation factor has a point value range of zero (0) to forty (40) points, using the Technical Rating Scale above, if the RFP Issuer evaluates the offeror's response as "Good," then the score for that evaluation factor is 4/5 of 40 or 32.

If subfactors are applied, the offeror's total technical score will be determined by adding the offeror's score for each subfactor. For example, if an evaluation factor has a point value range of zero (0) to forty (40) points, with two subfactors of twenty (20) points each, using the Technical Rating Scale above, if the RFP Issuer evaluates the offeror's response as "Good" for the first subfactor and "Poor" for the second subfactor, then the total score for that evaluation factor is 4/5 of 20 or 16 for the first subfactor plus 1/5 of 20 or 4 for the second subfactor, for a total of 20 for the entire factor.

### M.3 EVALUATION CRITERIA

The total sum of the maximum points for Technical Criteria and Price Criterion is 100 points. Proposals will be evaluated based on the following evaluation factors in the manner described below:

Technical Evaluation Factors	Points
Relevant Experience and References	25
Project Management Plan	25
Key Personnel	30
Price	20

Proposals will be evaluated based on the following evaluation factors in the manner described below:

#### M.3.1 TECHNICAL CRITERIA (80 Points Maximum)

**M.3.1.1 Relevant Experience and References:** The RFP Issuer wishes to engage a Contractor with the experience necessary to realize the goal and successfully complete the required work as described in this RFP. Complete Appendices I and II. This element is worth up to twenty-five (25) points.

**M.3.1.2 Project Management Plan:** This element of the evaluation is worth up to twenty-five (25) points.

**M.3.1.3 Key Personnel:** Offerors shall assign personnel to this Project with experience in fulfilling similar scopes of work. The element of the evaluation is worth up to thirty (30) points.

#### M.3.2 PRICE CRITERION (20 Points Maximum)

**M.3.2.1 Proposed Pricing Schedule:** The Contractor should respond in the format provided in Attachment A to this RFP listing every cost that is being proposed with a capped annual dollar amount for each cost. This element of the evaluation is worth up to twenty (20) points.

The price evaluation will be objective. The offeror with the lowest price will receive the maximum price points. All other proposals will receive a proportionately lower total score. The following formula will be used to determine each offeror's evaluated price score:

$$\frac{\text{Lowest price proposal}}{\text{Price of proposal being evaluated}} \times \text{weight} = \text{Evaluated price score}$$

#### M.3.4 TOTAL POINTS (112 Points Maximum)

Total points shall be the cumulative total of the offeror's technical criteria points, and price criterion points.

### M.4 EVALUATION OF OPTION YEARS

The RFP Issuer will evaluate offers for award purposes by evaluating the total price for all options as well as the base year. Evaluation of options shall not obligate the RFP Issuer to exercise them. The total RFP Issuer's requirements may change during the option years. Quantities to be awarded will be determined at the time each option is exercised.

## **M.5 EVALUATION OF PROMPT PAYMENT DISCOUNT**

**M.5.1** Prompt payment discounts shall not be considered in the evaluation of offers. However, any discount offered will form a part of the award and will be taken by the RFP Issuer if payment is made within the discount period specified by the offeror.

**M.5.2** In connection with any discount offered, time will be computed from the date of delivery of the supplies to carrier when delivery and acceptance are at point of origin, or from date of delivery at destination when delivery, installation and acceptance are at that, or from the date correct invoice or voucher is received in the office specified by the RFP Issuer, if the latter date is later than date of delivery. Payment is deemed to be made for the purpose of earning the discount on the date of mailing of the RFP Issuer check.

**APPENDIX I**  
**Background Information**

*Must be completed and submitted with all proposals.*

1. What is the legal name of your Firm?
  - a. *Include FEIN as this will be checked against DC and Federal Debarment lists.*
2. What is the Firm's headquarters mailing address?
  - a. *Attach DC Basic Business license (or state reason for exemption) and proof of business insurance*
3. How many years has your Firm been in business?
4. List name and title for the principals of the Firm.
5. What are the parent/subsidiary relationships in the Firm's organization?
6. Please describe the nature of all your business operations
  - a. *(e.g. major business lines, major markets served, Firm history)*
7. Please describe all of your operating units, subsidiaries, and affiliated Firms.
8. Please explain if anyone from your Firm (i.e., management, key employees, large shareholders) enter into any conflicts of interest by conducting business with the District and/or Hospital?
9. Does your Firm offer the proposed services via a GSA Schedule?
  - a. *Please provide number(s) for Schedule(s).*
10. Does your Firm offer the proposed services via a contract with a federal agency?
  - a. *Please provide number(s) for Contract(s).*
11. Please list the Group Purchasing Organization(s) of which your Firm is a member?

**APPENDIX II**  
**References**

*Must be completed and submitted with all proposals.*

List at least three (3) Healthcare customer references to which your Firm has provided services similar in size and scope to those being proposed.

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

List all terminated, cancelled or not-renewed Hospitals within the past two (2) years where your company provided Construction Services and list the same contact information that you did for the references above.

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

Company Name:	
Address:	
City/State/Zip:	
Business Phone:	
Contact Person:	Email:

**APPENDIX III**  
**Acknowledgement of Required Documentation**  
*Must be completed and submitted with all proposals.*

By signing below I acknowledge the following:

1. Any contract awarded as a result of this RFP effort will be awarded in the Hospital's Standard Contract Template (Example available from DHCF Chief Operating Officer and Deputy Chief of Staff, Kenneth Evans, upon request).
2. Prior to the date of award of any contract with the Hospital, my Firm will be required to provide the Hospital with a copy of my Firm's DC Basic Business License or other District of Columbia licenses or certifications, as applicable, and proof of insurance.
3. Prior to the date of award of any contract with the Hospital, my Firm acknowledges that it will be required to execute and/or incorporate all applicable documents listed in the table below. (links to documents found at <http://www.united-medicalcenter.com/about-us/doing-business-with-umc.html>)

<b>DOCUMENTS</b>
NFPHC Standard Contract Provisions
NFPHC Business Associate Agreement
First Source Agreement
LSDBE Subcontracting Plan
Living Wage Act of 2006
Department of Labor Wage Rates

4. The above-listed documents may not be changed or altered in any way.

Name (printed): \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ATTACHMENT A**

**Schedule of Values**

*Must be completed and submitted with all proposals.*

<b>BASE YEAR</b>		
<i>Contract Line Item Number (CLIN)</i>	<i>Description</i>	<i>Annual Not-to- Exceed Amount</i>
0001		
0002		
0003		
0004	Multiple Contract Discount	
<b>TOTAL AMOUNT</b>		

\*Insert additional CLIN Numbers as needed.