A NEW HOSPITAL AT ST. ELIZABETHS EAST

ANALYSIS OF A FINANCIALLY STABLE, HIGH QUALITY INTEGRATED MEDICAL CAMPUS AND AMBULATORY PAVILION

PROJECT #: DHCT-2017-R-0028

EXECUTIVE SUMMARY

March 2018

AGENDA

1. Objectives and Engagement Overview
2. Summary of Findings and Next Steps
3. Appendices: CLIN Summaries (1-6)

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OBJECTIVES AND ENGAGEMENT OVERVIEW

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SYNTHESIS OF RECOMMENDATIONS AND OUTPUT

Contract line item number ("CLIN") 7 provides a comprehensive review of Huron's findings, recommendations, considerations, and other output, in response to the questions solicited through each of CLINs 1-6

CLIN 1	CLIN 2	CLIN 3	CLIN 4	CLIN 5	CLIN 6
• Who are the utilizers of health care resources in Wards 7 and 8, and what factors influence how they utilize health care? • What is the ten-year market outlook for health care utilization in Wards 7 and 8?	▪ What are the potential impacts of changes in health care policy reforms, care delivery and reimbursement that can potentially affect hospital operations? • What are practical pursuits for D.C. to consider to support a viable hospital in ward 7 and 8?	▪ What are the key services utilized by Wards 7 and 8 residents, and where do they go to receive these services? • What is the framework for a replacement facility, given our findings from historical utilization and market outlook projections?	▪ What are the specific services and product line offerings; and expected bed size at the replacement facility? • What specific ancillary services should be offered at the replacement facility?	• What range of financing options exist and are feasible for D.C. to pursue for new hospital construction?	• What criteria and opportunity should be evaluated in identifying and negotiating with an operating partner? • What is the optimal operational and management archetype between D.C. and a potential partner? • What do the components of a request for proposal from such partners look like?

CLIN 1: UNDERSTANDING UTILIZATION

FACTORS DRIVING CARE DEMAND AND UTILIZATION

- The population of Wards 7 and 8, on average, is younger, less educated, and earns less, than residents elsewhere in D.C. Additionally, Wards 7 and 8 have the highest incidence of obesity (35% and 43%, compared to 23% District-wide), highest incidence of smoking (24% and 41%, compared to 20% District-wide), and highest rates of physical inactivity.
- There is significant opportunity for market share capture improvement, with UMC only capturing approximately 35% of potential inpatient market share from its primary service area.
- Community redevelopment is ongoing, specifically in Wards 7 and 8, which may significantly alter the demographics, socioeconomics, and health care demands of the residing population.

Key Takeaways:

1 Payor mix in the primary service area ("PSA") of UMC has historically been unfavorable, and projected to remain so. While over 90% of residents in Wards 7 and 8 maintain health coverage, the majority do so through Medicaid, which accounts for ~56% of the of the payor mix. Commercial insurance accounts for approximately 30% of the payor mix and Medicare accounts for roughly 10%.

2 Inpatient demand will experience modest gain (+3.5% in 2027) in Wards 7 and 8 and lags behind outpatient ("OP") demand (+23% in 2027) likely due to evolving care delivery models, technology enhancements, and reimbursement changes. Demand for OP care is robust, with billed procedures projected to grow by 23% in 2027, compared to 2017

3 Projecting from current care demand and associated revenue, inpatient ("IP") growth will account for an additional $14M in net patient revenue in 2027 compared to 2017. General Medicine, Behavioral Health, and Nephrology are among service lines that will experience robust IP discharge growth, while Cardiovascular and Women's Health discharges are projected to decline between 2017 and 2027.

4 Between 2017 and 2027, care demand growth is projected across all outpatient service lines within the PSA. Oncology, and Nephrology are projected to see most significant growth (volume and revenue), with Cardiology showing strong growth in OP settings, which may account for projected declines in IP volume. Outpatient lab, imaging, and other diagnostic services account for nearly two million billed procedures in 2027, after growth of 19% from 2017.

CLIN 2: UNDERSTANDING IMPACTS OF POLICY

REPEAL OR REPLACEMENT OF ACA MAY SIGNIFICANTLY IMPACT ELIGIBILITY AND ENROLLMENT

- While repeal efforts have not been successful, through rulemaking, Executive Orders, and other policy nuance, stability in the Individual Market is still under threat. Funding for, and eligibility and access mechanisms to Medicaid, however, for the time being, appear secure at current levels.
- Per recent estimates from Kaiser Family Foundation, ACASignups, as well as enrollment reports from HHS, the Administration's direction to not fund Cost Share Reduction (CSR) payments will not impact a significant number of DC Marketplace plan enrollees. Only ~500 of the ~18,000 enrollees receive CSR subsidies.

Key Takeaways and Updates:

1 As of September 30, 2017, funding for the Children's Health Insurance Program (CHIP) expired, with Congress failing to reauthorize to-date. In 2016, over 98% of eligible children in D.C. participated in Medicaid or Healthy Families, with over 13,000 enrollees in CHIP over the course of the fiscal year.

2 With the ACA remaining mostly intact, the federal Medicaid Disproportionate Share Hospital (DSH) allotment reduction will remain and impact FY18. DC will see a 15.5% reduction in DSH allotment. There are pieces of legislation (tied mostly to renewal of CHIP funding) that see further delay DHS payment reductions.

3 Legislation mirroring past ACA repeal efforts would have significant impact on the uninsured rate in Wards 6, 7, and 8, as well as Prince George's County, MD (nearly 30,000 additional uninsured between 2017 and 2027).

4 Despite uncertainty, national trends continue to show value in embracing risk and value within contracts with payors. However, D.C. hospitals have historically not performed well in the compulsory programs that impact Medicare payments (Readmissions Reduction Program, Hospital-Acquired Conditions Penalty, and Value-based Purchasing Adjustment Factor).

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CLIN 3: UNDERSTANDING SERVICE PREFERENCE

MAPPING CARE ACCESS PREFERENCES OF WARD 7 AND 8 RESIDENTS

- Residents in the PSA predominantly seek care from facilities in Central D.C., for a broad range of acute and non-acute services. This is largely due to negative perceptions around breadth of service mix, quality of care, and patient experience at the current UMC facility.
- Provision of a broad array of targeted services aligned to the population needs, ambulatory and ancillary services to expand access points to the residents, and improvement in patient outcomes and experience will be essential for a replacement facility to improve its utilization rate and payor mix and in order to achieve financial viability.

Key Takeaways:

1 Inpatient (IP) utilization among PSA Medicaid beneficiaries declined by 3% between 2014 and 2016. Outpatient (OP) utilization, however, increased by 8% during same period. **This aligns to market forecast and national trends,** suggesting a continued shift to outpatient from inpatient services.

2 In 2016, clinical services were sought among D.C. hospitals most of the time (92% for IP, 95% for OP services) with little outmigration to non-D.C. facilities. PGHC, MSMHC, and FWH accounted for majority of non-D.C. destinations.

3 For adult IP services, **WHC is the most competitive among D.C. hospitals**, with 22% market share. GWUH and UMC ranked 2nd and 3rd with 19% and 18%, respectively.

4 For adult OP services, Washington Hospital Center is the most preferred destination. While UMC ranked second overall, **market share is lowest in high demand service lines such as Oncology and Orthopedics**.

5 Unlike in adult services, Children's is the preferred destination for pediatric IP and OP services (overall market share of ~40% IP and ~90% OP). **Most of these services were provided at the Children's facility located on UMC's campus.**

6 Ancillary services (for example, labs, dialysis, SNF) show robust utilization from PSA Medicaid beneficiaries. **Ability to provide ancillary services will improve resident access points to and utilization of a replacement facility.**

GWUH: George Washington University Hospital; **WHC**: Medstar Washington Hospital Center; **UMC**: United Medical Center; **PGHC:** Prince George's Hospital Center; MSMHC: Medstar Southern Maryland Hospital Center; **FWH**: Fort Washington Hospital; **Children's**: Children's National Medical Center.

CLIN 4: DEFINING AN OPTIMAL DESIGN

CLINICAL PROGRAM, FACILITY MODEL AND ACCESS

- An Integrated Medical Campus with Ambulatory Pavilion is the recommended delivery model for a facility in Southeastern District. This model is in-line with national trends that currently emphasize focused inpatient (IP) capabilities with robust outpatient (OP) and ancillary services delivered in more accessible and patient friendly environment.
- Assumptions around seven key levers were used to model three market scenarios based on projected market capture rates. For these market scenarios – low, medium and high – projected inpatient bed needs were estimated to be 96, 121 and 138 respectively in 2027 at 80% utilization rates. Bed needs, however, could potentially be modified by other considerations such as DSH "no cap" payments requiring a minimum of 100 beds, potential partner's inpatient service line preferences and their strategic objectives for managing the new facility.
- For budgeting purposes, Huron analysis indicates estimated hospital replacement costs at $2M per bed. This estimate varies significantly, depending on a number of factors discussed in CLIN 4, including facility type and size, as well as clinical program.
- Discounting the unknowns and decisions yet to be made that will shape the new facility, an operational stabilization period of three-to-five years should considered when accounting for potential financial support needs beyond construction and start-up.

Key Takeaways:

1 Revenue estimates for NewCo in low, medium and high scenarios range from $148M - $215M in 2027 excluding ancillary services such as laboratory and radiology services. Low market revenue projections of $148M in 2027 compares favorably to revenues of $120M for existing UMC in 2016 **(~25% increase), despite significantly smaller IP footprint**.

2 For IP services, focus recommended on 9 service lines based on market demand and D.C Medicaid claims data. **OP focus is broader with some service lines such as Oncology, ENT and Ophthalmology requiring only OP offerings** due to very robust OP and minimal IP demand.

3 Presence of an urgent care center within NewCo could potentially help to reduce ER visits by 13-27%. However, **initiatives to modify residents perception and behavior towards ER utilization** will be needed if significant volume steerage is to be achieved.

4 Presence of ancillary services such as radiology (including imaging), laboratory, PT/OT and hemodialysis unit within campus **helps strengthen campus reputation as a "one stop shop" for access by residents**. Divesting options should however be considered for SNF and ideal location for new entity to be decided in collaboration with acquirer (or third party operator).

Model revenue projections assumes 80% of Medicare reimbursement rate for Medicaid beneficiaries, 5% of projected volume as uninsured care, reimbursement at 2017 DRG rates without factoring additional reimbursements that can be obtained as a new entity with potentially higher reimbursement structure

CLIN 5: IDENTIFYING FINANCING OPPORTUNITIES

OPTIMAL SOURCE FOR BOTH DC AND OPERATING PARTNER

+ The ultimate financing decision cannot be made in isolation. Decisions around operating partners and their share of the financial burden and the District's long-term plans around the new hospital project need to be weighed and considered.

Key Takeaways:

1 The most viable financing options appear to be a combination of one or more of the following: District and/or partner contributions, HUD-insured tax-exempt bonds or GNMA mortgage-backed securities, or a public-private partnership ("P3").

2 If the option to pursue a bond raise is chosen, the ability to issue tax-exempt bonds will depend on the operating partner and ownership of the new facility.

3 Traditional bank financing and private equity sponsorship may be viable options, but the cost of funds will likely be more expensive than other options.

4 In order to obtain HUD insurance, HUD may require waivers related to the proposed operating and ownership structure of the hospital. For example, HUD generally would not permit the District to own the facilities and the partner to own the operations.

5 The Canadian P3 model for healthcare projects appears viable, but has not been utilized for hospital construction in the United States. The District's Office of Public-Private Partnerships ("OP3") can be leveraged to determine the feasibility of the P3 model and facilitate a P3 structure for the new hospital.

6 Regardless of the financing source chosen, the District will need to demonstrate how the new hospital will be different from United Medical Center.

CLIN 6: ASSESSING VIABLE PARTNERSHIPS

SELECTION OF PARTNER AND TRANSACTION STRUCTURE

- An asset acquisition or long-term lease are the transaction structures that best accomplish the District's goal of exiting the hospital business. A management agreement could potentially be utilized if no acceptable primary partner emerges for NewCo.
- Based on partner responses, there appear to be several options for primary partners, plus others for secondary partners.

Key Takeaways:

1 Management archetypes vary based on level of integration and the roles of the potential partners. However, a comprehensive transaction model (long-term lease or asset acquisition) will likely best accomplish the District's goal of turning over operating and financial responsibility to a qualified health system.

2 Potential partners were reviewed based on District-approved criteria and organized into three tiers based on the best fit for the District and NewCo.

3 Huron held preliminary conversations with all Tier 1 (in-market systems who can serve as the primary partner) and Tier 2 (potential secondary or service line partners) organizations. Tier 3 (national health systems with no market presence) organizations were not contacted given the limited synergies with those organizations. Finding the right primary partner is the first order of priority for the District.

4 The most expedited process to select a preferred primary partner is direct negotiation with one or more organizations. We recommend this option if feasible.

5 A formal request for proposal (RFP) process may be needed due to (i) legal requirements or (ii) the number of potential candidates. If the District elects to pursue the primary partner through such a process, the timing will likely extend well into 2019.

6 Once the preferred partner has been selected and a MOU is executed, a due diligence phase will begin, with the goal of finalizing partnership details, facility design, a project timeline and other details.

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SUMMARY FINDINGS AND NEXT STEPS

SUMMARY FINDINGS AND RECOMMENDATIONS

- An asset acquisition or long-term lease are the alignment structures that best accomplish the District's goal of exiting the hospital business. A management agreement can be utilized if no acceptable primary partner emerges for NewCo.
- Based on partner responses, there appear to be several options for primary partners, plus others for secondary partners.
- The most expedited process to select a preferred primary partner is direct negotiation with one or more organizations. This process would consist of:
  - Comparison of the interested parties to the District's established partnership criteria, with the intent of identifying one or more finalists
  - Selecting a preferred partner and negotiating the structure of the venture
  - Continued meetings between the parties to develop a framework for the proposed venture
  - Request written and nonbinding proposals from the finalists that outline their value proposition, proposed deal framework and commitments
  - Allow the finalists to present their proposals
  - Selection of preferred primary partner
  - Execute a memorandum of understanding between the parties

SUMMARY FINDINGS AND RECOMMENDATIONS

- A formal request for proposal (RFP) process may be needed due to (i) legal requirements or (ii) the number of potential candidates. If the District elects to pursue the primary partner through such a process, the timing will likely extend well into 2019 and delay the hospital opening. In accordance with applicable laws, the following activities will be required to undertake the RFP process:
  - Establishment of a panel that has the responsibility of reviewing bidding documents and selecting the winning bidder
  - Panel will evaluate each potential partner against approved partner criteria
  - Preparation of the initiation to propose and the bidding documents
  - Issuance of the RFP and supporting documents
  - Conduct pre-proposal conference
  - Submission of proposals by interested parties
  - Opening of proposals
  - Conduct proposal evaluation
  - Preparation of proposal scorecard
  - Approval of the winning party
  - Issuance of the Notice of Award and the draft contract
  - Approval of the signed contract
  - Issuance of Notice to Proceed to the winning bidder

SUMMARY FINDINGS AND RECOMMENDATIONS

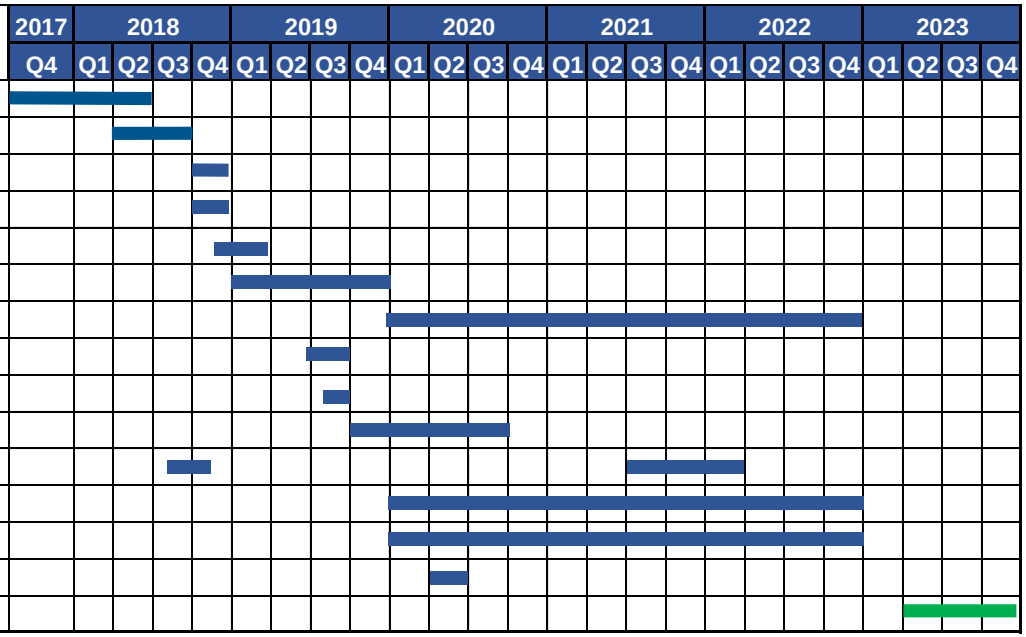
- Once the preferred partner has been selected, a detailed, “partnership agreement” strategic planning process will begin. The intent of the studies will be to determine, among others:
  - Timeline
  - Size and scale of facility, including costs
  - Service lines
  - Facility design
  - Preferred financing option
  - Financial commitments of the partner and District
  - Pro forma for the venture
  - Inclusion of secondary partners
  - Transition process for UMC
  - Engagement of outside advisors
  - Governance structure of new hospital
  - Robust public engagement

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

These activities carry highly variable timeframes; however, similar projects typically span four to six years. Shown below is an aspirational timeline for the project.

	Activity	Timeline
1	Partnership selection process	9 months
2	Partner negotiations	6 months
3	Develop project cost and secure funding	3 months
4	Centralized technology infrastructure plan development	3 months
5	Discussion with CON office to streamline CON process	4 months
6	Detailed project planning and design	12 months
7	Project construction commencement	36 months
8	Revision of reimbursement structure (in collaboration with DHCF)	3 months
9	Application assistance for provider numbers	2 months
10	Transition planning for closing existing hospital	12 months
11	Community engagement, communication strategies on NewCo	12 months
12	Project management office	36 months
13	Ongoing oversight / overall project supervision	36 months
14	Develop District's strategy for care delivery in southeastern D.C.	3 months
15	**Operations**	



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NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
1.	**Partnership selection process** The objective is to select the ideal primary partner for NewCo. This involves evaluation of interested parties based on identified selection criteria from the CLIN 6 deliverable and conducting due diligence on the finalists. Based on the above process, the primary partner for NewCo is selected and a MOU is signed. After primary partner selection, potential secondary partners for selected clinical or ancillary services (for example, pediatrics service line and dialysis center) will be considered, if necessary. There are two options for the process to select a preferred primary partner: (1) direct negotiation with a limited group of parties or (2) an RFP process. Our recommendation is a direct negotiation process, given that it is the most expedited method to select a preferred primary partner. This process would consist of: • Comparison of the interested parties to the District's established partnership criteria, with the intent of identifying one or more finalists • Selecting a preferred partner and negotiating the structure of the venture • Continued meetings between the parties to develop a framework for the proposed venture • Request written and nonbinding proposals from the finalists that outline their value proposition, proposed deal framework and commitments • Allow the finalists to present their proposals • Selection of preferred primary partner • Execution of a memorandum of understanding between the parties	2017 / 2018

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
1.	**Partnership selection process (continued)** If an RFP process is required, the following select activities make up the RFP process after the scope and other bid documents are finalized, in accordance with applicable laws. • Preparation of a panel that has the responsibility to review bidding documents and select the winning bidder • Panel to evaluate each potential partner against potential partner criteria • Preparation of the initiation to propose and the bidding documents • Issuance of the RFP and supporting documents • Conduct pre-proposal conference • Submission of proposals by interested parties • Opening of proposals • Conduct proposal evaluation • Preparation of proposal scorecard • Approval of the winning party • Issuance of the Notice of Award and the draft contract • Approval of the signed contract (including any required governmental approvals) • Issuance of Notice to Proceed to the winning bidder	2017 / 2018

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
2.	**Partner negotiations** The objective is to secure alignment with potential partner(s) on financing options, clinical programs, and framework for optimal design of the facility. Further, these activities include ensuring the District's interests are adequately represented in all discussions. **Financial negotiations** involve facilitating discussions of financial options and deal structure. The objective is to design and execute a management arrangement that provides the partner with necessary autonomy to operate the facility and ensures the partner's long-term commitment to NewCo. **Clinical negotiations** involve discussions focused on design of inpatient and outpatient services. To ensure a comprehensive representation of the District's interest, an advisor will facilitate discussions between DHCF and DOH, DBH, DDS, and CFSA as well as other stakeholders. Report on agreed relevant services will be used in negotiations with partner. In addition: • Primary partner will have first right of refusal for ancillary services and other service lines (for example, dialysis, imaging services, or PT/OT services). • Refused services will be followed up with recommendation for District to request third party solicitation. **Facility design negotiations will be partner dependent.** If the partner has a preferred design and construction company for facility, negotiations may begin with them but are subject to District's preference. Otherwise, an advisor will facilitate the process. **Execute a comprehensive "partnership agreement"** with the selected partner to affirm the commitment of the District and partner of issues on slide 14.	2018

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
3.	**Develop project cost and secure funding** A hospital construction company will provide detailed guidance on the cost of NewCo based on bed size and/or services and phases of construction. If potential partner has a preferred construction company and they are responsible for developing project estimates, the advisor will work with D.C.'s Department of General Services Contracts and Procurement Division ("DGS") to validate estimates externally. Also, the advisor will iterate with the Office of the CFO, CA, and Councilmembers to secure funding. Finally, advisor will engage with the GSA office to facilitate issue of an RFP with relevant specifications required for construction of NewCo.	2018
4.	**Centralized technology (IT and clinical) infrastructure plan development** This ensures a robust hospital wireless network infrastructure is developed for NewCo and potentially serves as a blueprint for the construction company to integrate into its construction plans. Strategic development of robust wireless networking infrastructure is not typically within the purview of construction companies.	2018
5.	**Discussion with CON Office to Streamline CON Process** The objective is to ensure a streamlined CON process is in place for all services to be offered at NewCo, including acute care, ambulatory services, and dialyses. Advisor will also help facilitate a one-time waiver on CON moratorium from the CA's office.	2018
6.	**Detailed Project Planning and Design** Provide overall guidance, define key milestones and timing, as well as specific tasks related to NewCo's development, design, and construction, from initiation to completion. Project planning will also define and document the project's scope, key assumptions, risks, and mitigation actions to ensure successful completion.	2019

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
7.	**Project Construction Commencement** Initiation of installation of infrastructure and project construction in phases agreed upon by partner and District.	2020
8.	**Revision of Reimbursement Structure / State Plan Amendment ("SPA") Changes for NewCo** Facilitate discussions between partner(s) and DHCF to develop new interim rates for acute care and other services at NewCo as a new medical facility to address and support the new facility and other care delivery system elements in a challenged reimbursement environment. These rates can be audited annually.	2019
9.	**Application Assistance for Provider Numbers** This includes obtaining two certifications independently from DOH and DCRA before the application for provider number for services to be offered at NewCo. Advisor will assist partner(s) with all steps, working in collaboration with relevant District officials.	2019
10.	**Transition Plan for Closing Existing Hospital** Advisor will help oversee planning of the appropriate transition of services, the proper handling of all medical records from current UMC, disposition of union contracts, negotiation of severance pay, reuse of current UMC land, and other legal issues.	2019 - 2022
11.	**Community Engagement** The objective is to create awareness of NewCo among the community and develop the initial communication and marketing strategies. Advisor will facilitate town hall meetings between District officials, operating partner(s), and community members to increase awareness of services to be offered in NewCo.	Mid 2018 – 2022

NEXT STEPS

KEY ACTIVITIES AND TIMEFRAME

No.	Key Step	Timeline
12.	**Project Management Office (PMO)** The PMO ensures construction of NewCo is on target to meet expected completion date and works to mitigate cost overruns and manage change orders.	2019
13.	**Ongoing Oversight / Overall Project Supervision**[1] Advisor provides ongoing oversight to ensure various key steps and timelines are on target for breaking ground and completion of facility. Thereafter, advisor acts as an independent contractor to protect District's interest as the new partner(s) operates NewCo in lieu of a fiduciary board (the official middle man). Advisor ensures the District receives periodic reports on operational and financial performance of NewCo and helps the District communicate expectations to the operator.	2019
14.	**District and potential partner to develop strategy for care delivery in southeastern D.C.** The objective is to assess the competitive position of NewCo and how it will develop care coordination strategies with other care providers (for example, FQHCs, SNFs, and dialyses centers) in Wards 7 and 8 to ensure residents' access to integrated care and promote facility reputation as a destination medical center.	2020

[1] These details could change as discussions progress.


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THANK YOU