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

FULL REPORT SUMMARY

March 2018

AGENDA

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

1

OBJECTIVES AND ENGAGEMENT OVERVIEW

OBJECTIVES AND ENGAGEMENT OVERVIEW

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).

HURON

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.

2

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

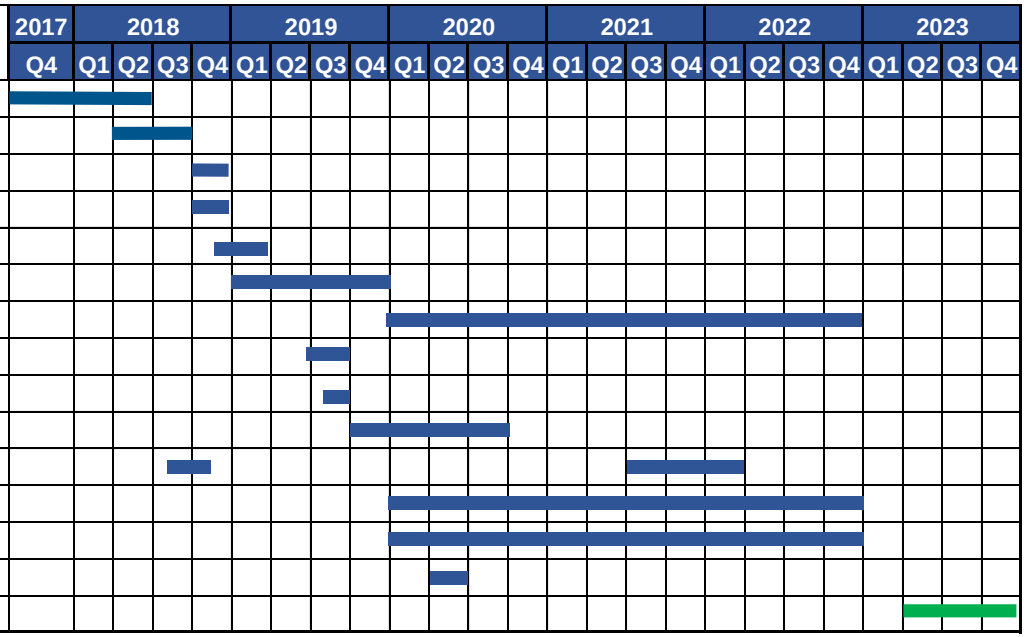
- Once the preferred partner has been selected, a detailed, “partnership agreement” strategic planning process will begin. The intent of the studies will be to determine, among others:
  - Timeline
  - Size and scale of facility, including costs
  - Service lines
  - Facility design
  - Preferred financing 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**	



HURON

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.

3

CLIN SUMMARIES (1 THROUGH 6)

3.1

CLIN 1 – UNDERSTANDING UTILIZATION

ENVIRONMENT DRIVES UTILIZATION

Ward 7 and 8 Residents' Care Demand Is Likely Influenced by Socioeconomic Factors

Who are the utilizers of health care in Wards 7 and 8, and what factors influence their use of health care resources?

Demographics

Access & Coverage

Health Status

Compared to the rest of D.C., residents of Wards 7 and 8 are:

- Younger (28% less than 18 years vs. 16% rest of D.C.)
- More likely to be unemployed (22%)
- Earn less
  - 63% of households earn less than $50k per year
  - 25% of households earn less than $15k per year
- Less educated (16.5% with less than high school diploma)
- Disproportionately enrolled in Medicaid (56%)
- Less healthy, with a greater chronic disease burden and poorer health indices
  - Higher incidence rates of obesity, smoking, and physical inactivity

WARDS 7 AND 8 CONTINUE TO GROW

Population Changes Will Disproportionately Impact Care Demand

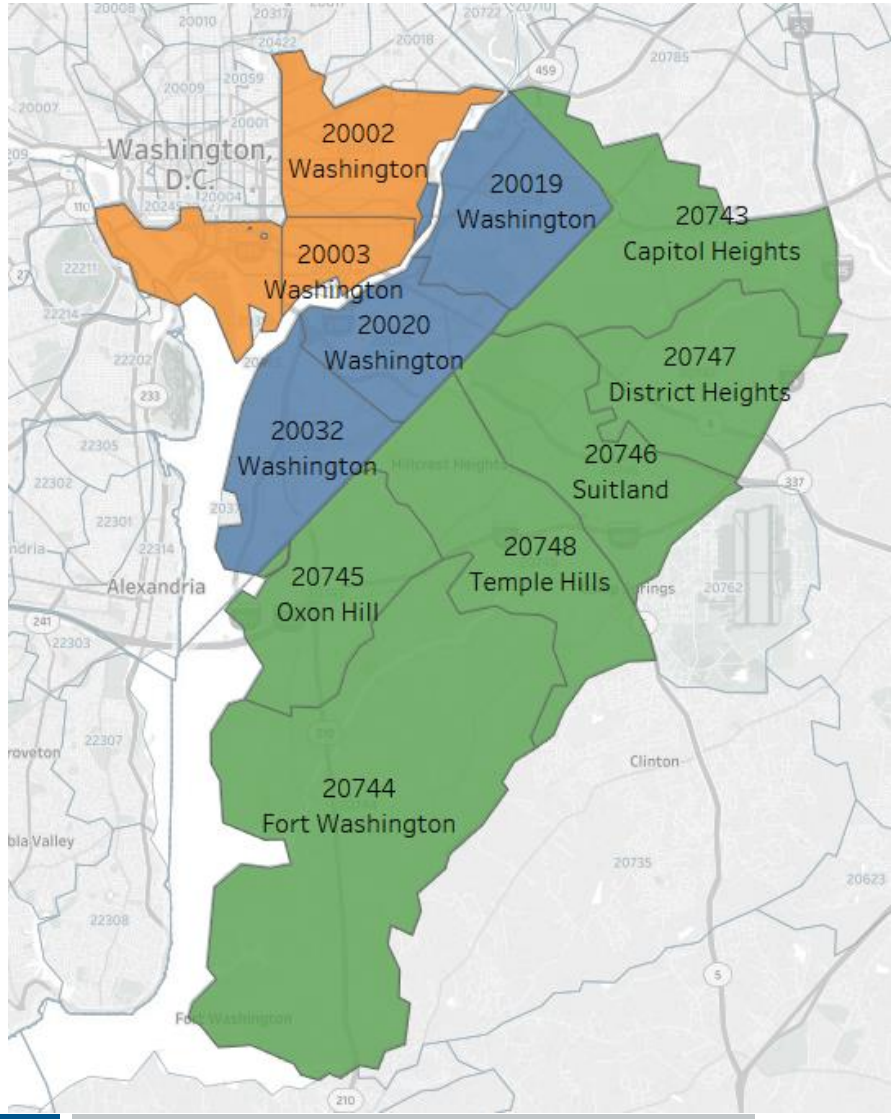
What is the ten-year outlook in care demand, and what are the drivers of utilization?

- ❑ Growth and Utilization Drivers
- ❑ Projected Inpatient Demand for the market, 2017 – 2027
- ❑ Projected Outpatient Demand for the market, 2017 – 2027
- ❑ Key Service Lines
- ❑ Major Diagnostic Categories

- The PSA population is expected to grow 5% by 2022 and 11% by 2027.
- **Seniors (21%) and the pediatrics (7%) are the fastest growing demographics** in the PSA, but adults aged 35-64 years are the majority.
- **Inpatient demand** will experience modest gain (+3.5% in 2027) in Wards 7 and 8.
  - Key, growing service lines include: General Medicine, Behavioral Health, and Nephrology.
  - Cardiovascular and Women's Health discharges will decline.
  - Ten diagnostic categories will account for over 80% of demand (discharges).
- **Outpatient demand** is projected to grow 23% by 2027.
  - OP demand will be influenced by progressive care delivery models, technology enhancements, and reimbursement changes.

DISCUSSION HIGHLIGHTS

COMPARING UMC'S SERVICE AREAS



PSA

Demand in the PSA is significant and disproportionately higher than the rest of the total service area.
The PSA represents **23%** of the total area's population but will generate **36%** of total service area IP demand (over 21,000 IP discharges) and **31%** of total service area OP demand (over 5.3 million outpatient procedures).

SSA-D.C.

Ward 6 represents a much **wealthier, more educated, and relatively younger** population. Care demands align with those of residents in PSA, but residents likely seek a better care experience. A new facility for Wards 7 and 8 must differentiate itself as a care destination versus more accessible locations in Ward 6.

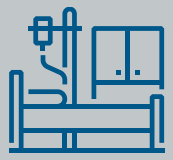
SSA-MD

The Prince George's County, MD market represents the greatest opportunity for revenue, due to a more favorable payor mix. In 2027, this market is expected to see an a**dditional $31M in attributable inpatient revenue**, following growth of over 5%. However, much of this volume and revenue opportunity likely bypasses existing facilities in Wards 7 and 8 and/or is served by more proximal facilities in the southern reaches of the service area.

CURRENT VOLUMES NOT VIABLE

New Facility Will Need to Capture Additional Market Share within PSA

How do they utilize health care resources currently, and what are the current trends in care demand?



UMC Assessment

- ❑ IP Discharges
- ❑ OP Visits
- ❑ Inpatient versus Outpatient demand and PSA market share

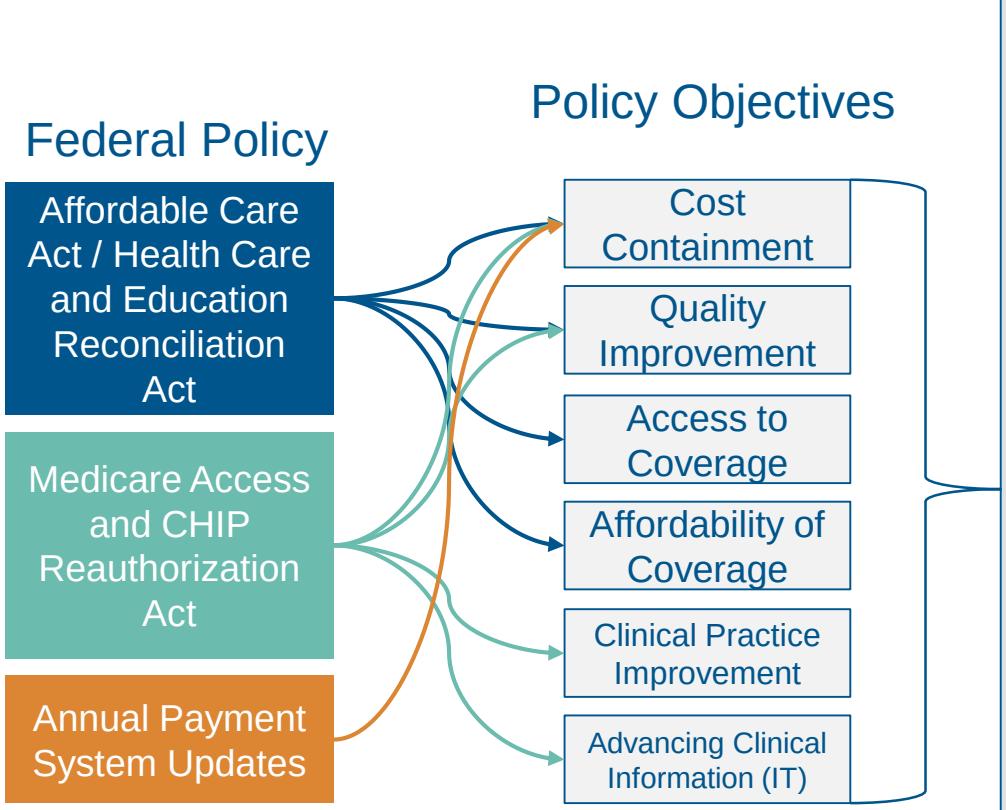
- UMC has experienced recent, **modest growth in care utilization**.
  - 3.7% increase in IP discharges between 2014 and 2016
  - 8.9% increase in OP visits between 2014 and 2016
- Since 2014, UMC has an 18% increase in IP discharges originating from MD service area zip codes (PG County).
- UMC has seen a **significant decrease in utilization from Ward 6** (16% decrease in IP; 3% decrease in OP).
- 2017 estimates project PSA IP market share at 35%.
- 2017 estimates project over 87,000 OP visits (encompassing hospital-based outpatient and ER volume).

3.2

CLIN 2 – UNDERSTANDING IMPLICATIONS OF POLICY

CURRENT POLICY ENVIRONMENT

MAJOR MARKET AND HOSPITAL OPERATIONAL IMPACTS ARISE FROM TWO KEY PIECES OF LEGISLATION AND ANNUAL RULEMAKING



Realized Impacts for Hospitals

- Reduced uncompensated care
- Increased utilization from insured
- Increased patient revenues
- Increased risk on Medicare payments
- Reduced DSH allotment
- Increased penalties/negative payment adjustments for poor performance
- Increased transparency to public
- Increased consolidation
- Increased integration

EMERGING POLICY ENVIRONMENT

FOCUS OF REPEAL AND REPLACEMENT PROPOSALS CENTERS ON FOUR AREAS OF PAYMENT AND DELIVERY REFORM

Key Components of Replacement Proposals

- Repeals individual and employer mandates
- Repeals ACA taxes
- Emphasis/expansion on health savings accounts
- Targeted tax credits to support affordability
- Reduces regulations on coverage requirements, benefits, guaranteed availability, and other market rules
- Medicaid overhaul
- Medicare funding refinement

Realized Impacts for Hospitals

- Increase in uncompensated care
- Decrease in utilization from commercially insured individuals
- Decrease in reimbursement via Medicaid
- Uncertain implications to value-based Medicare programs
- No reduction in DSH payments (as per ACA)
- Decrease in burden from provider taxes

EMERGING POLICY ENVIRONMENT
IMPACTS TO D.C.: FUNDING AND COVERAGE

Federal Medicaid Cuts under BCRA due to Per Capita Cap and Expansion Financing Changes
(Figures in billions)

Federal Spending Under Current Law for D.C.	If D.C. Drops Expansion Coverage in 2021			If D.C. Maintains Expansion Coverage		
	Federal Per Capita Cap Cuts	Federal Expansion Cuts	Combined Federal Cuts	Federal Per Capita Cap Cuts	Federal Expansion Cuts	Combined Federal Cuts
$16.8	-$0.6	-$2.8	-$3.3	-$0.7	-$0.5	-$1.2

Enrollment Implications of BCRA to D.C. Medicaid

Enrollment Under Current Law in 2021			Enrollment Impact of BCRA if D.C. Drops Expansion Coverage					
All Enrollees	Expansion Adults							
	#	% of Total	2021	2022	2023	2024	2025	2026
247,000	64,000	26%	-64,000	-65,000	-65,000	-65,000	-66,000	-66,000

Estimates only consider the impact from the loss of expansion; additional coverage losses may occur due to the per capita cap, particularly in later years

Enrollment Implications to Project Focus Area

Service Area	Change in Medicaid Expansion Lives (2017-2027)	Change in Commercial Lives (2017-2027)	Change in Exchange Lives (2017-2027)	Change in Uninsured Lives (2017-2027)
Wards 7 and 8	-5,000	+3,800	-7,503	+8,700
Ward 6	-3,000	+5,200	-5,400	+3,200
PG County, MD	-14,000	+6,500	-10,000	+17,000

Analysis from Huron Modeling, Truven Analytics, RWJF, and KFF

IMPACTS TO D.C.: CARE DEMAND AND UTILIZATION

WARDS 7 AND 8 CARE DEMAND COMPARISON - INPATIENT

IP Growth Snapshot

3.6% **Expected Inpatient Demand Growth** 2017 – 2027

7% **Expected Inpatient Days Growth** 2017 - 2027

4.1 **Expected ALOS** 2027

Repeal Scenario— IP Growth Snapshot

3.0% **Expected Inpatient Demand Growth** 2017 – 2027

9% **Expected Inpatient Days Growth** 2017 - 2027

4.9 **Expected ALOS** 2027

In a repeal scenario, projections for 2027 indicate:

- Decrease in inpatient admission volumes by 15% from current projections
- Increase in expected ALOS (across all service lines), by 20%
- 80% increase in IP demand from uninsured

- IP growth remains modest and steady in either scenario. An increase in inpatient days growth and expected ALOS likely due to less utilization of preventive, primary, and other outpatient services. With less care access options, uninsured individuals will delay care until illness is more severe, resulting in increased acuity levels.
- Adjusting the expected ALOS to observed ALOS reduces this figure to 4.2, however the increase from 4.1 to 4.9 days does support the assumption of higher acuity and disease burden in a repeal scenario.

Analysis from Huron Modeling and Truven Analytics

IMPACTS TO D.C.: CARE DEMAND AND UTILIZATION

WARDS 7 AND 8 CARE DEMAND COMPARISON - OUTPATIENT

OP Growth Snapshot

25% **Expected Outpatient Demand Growth**
2017 – 2027

Repeal Scenario— OP Growth Snapshot

19% **Expected Outpatient Demand Growth**
2017 – 2027

ER Growth Snapshot

34% **Expected ER Demand Growth**
2017 – 2027

Repeal Scenario— ER Growth Snapshot

33% **Expected ER Demand Growth**
2017 – 2027

- In a repeal scenario, projections for 2027 indicate a decrease in outpatient billed procedure volumes by 20%
- In a repeal scenario, uninsured utilization of the ER will grow 120% between 2017-2027, vs. 40% in a status quo scenario

- A decrease in non-ER outpatient growth is not surprising in a repeal scenario. With fewer insured individuals, demand for preventive, primary, secondary, and other elective care inherently decreases.
- ER demand was not substantively impacted by the ACA, with utilization rates and growth remaining steady since 2012. The increase in uncompensated care in the ER is significant, and will partly drive higher acuity and ALOS projected for inpatient admissions

Analysis from Huron Modeling and Truven Analytics

IMPACTS OF POLICY ON HOSPITAL OPERATIONS

APPROACH TO ANALYSIS AND RECOMMENDATIONS

- Viable hospitals require stable environments across all of these operational factors, each of which sees impacts from payment and delivery system policy.
- Payment and delivery system reform has both direct and indirect influence on hospitals operations.
- New policies targeting both direct and indirect influence objectives will best position a new facility for success.

Considers the reimbursement environment for a new facility, including favorability of payor mix as well as the complexity, maturity, and structure of payor and other partner contracts (fee-for-service, percent at risk, etc.).

Considers opportunity, efficiency, and structure of hospital's costs and organizational structure, including complexity of system and operating model of the organization.

Key Operational Factors

Accounts for how the facility is positioned for success within its environment, including differentiation factors,

Considers the makeup, maturity, and critical needs of the delivery environment, including new facility differentiation factors, direct competitors, partners, and other competitive measures.

BUILDING A SUSTAINABLE ENVIRONMENT

DEVELOPING AND INVESTING IN HEALTHCARE CAPABILITIES

Policy/ Initiative	Purpose	Discussion of Actions and Impacts
Public-Private Partnership (P3s)	Spur development of healthcare delivery system in Wards 7 and 8	• Attract partners and investors • Support development of infrastructure and capabilities in areas D.C. has identified as critical need • Steer private operators on service and care delivery objectives • Support state health innovation objectives through private partnership • Consider alternatives for financing and contracting
Adjustment to existing Certificate of Need requirements and/or	Allow faster, less-restrictive development of healthcare facilities and services	• Temporary moratorium on CON approvals in D.C. • Temporary CON requirements' ease for Wards 7 and 8 supports development of primary and ancillary needs in complement to new facility
Launch a Healthcare HubZone in Wards 7 and 8	Spur development of healthcare delivery system in Wards 7 and 8	• Leverages existing SBA designation for non-clinical development needs that support hospitals (retail, lodging, etc.) • Serves as foundation for economic incentives/adjustments to area that are focused on healthcare development
Temporary relief of D.C. Hospital Provider Fee for new facilities in Wards 7 and 8	Support new facility's IP revenues in early years	• Supports more favorable financial outlook on IP margin as facility opens and scales up operations
Economic Indicator Rate Adjustment for HubZone area	Incentivize development of robust delivery system via rate adjustment	• A rate increase, or other rate incentive will support faster development of delivery system • Supports more sustainable environment in early year operations, as delivery system develops around new facility
Augment existing physician recruitment and support programs	Encourage providers in targeted specialties to practice in D.C.	• Extending HPLRP Service Obligation Site designation to new facility for primary care, mental health, and other key specialties will support adequate staffing of the new facility, as well as other sites of care that open in Wards 7 and 8.

BUILDING A SUSTAINABLE ENVIRONMENT

PROMOTING QUALITY, VALUE, AND EFFECTIVE CARE DELIVERY

Policy/Initiative	Purpose	Discussion of Actions and Impacts
Pilot a partnership program with Medicaid MCOs for care and case management of Medicaid FFS beneficiaries	Improve quality and drive more effective utilization	• Upside-only model – drive down utilization and share in savings • Upside/Downside model – establishes a risk corridor with funds flow based on MCO performance
Pilot a Medicaid ACO program or specific condition(s) and/or population (segment or geography)	Defer risk, improve outcomes, drive down cost	• Incentivizes coordination of patient services • Supports transition to capitated payments • Aligns objectives of governing body and MCOs
D.C. Patient Centered Medical Home model	Defer risk, improve primary care access and care coordination	• Improve utilization of PCP, reduced utilization of ER • Reduce costs via improved coordination of care
Develop and implement accountable health community model for partnership with new facility	Fill gaps between clinical care and community services	• Improved navigation between community elements, primary care, and hospital care • Optimized care delivery • Non-acute needs are addressed in community instead of clinical site
Urgent Care Partnership	Develop referral paths from area urgent care clinics to new facility	• Urgent care becomes front-door for new facility, reducing demand on ER while maintaining path to IP and OP services • A focus on Wards 6 and Prince George's County, MD supports flow from extended service area • Alignment with FQHC and community partners to avoid decanting volume from those sites

3.3

CLIN 3 – UNDERSTANDING SERVICE PREFERENCE

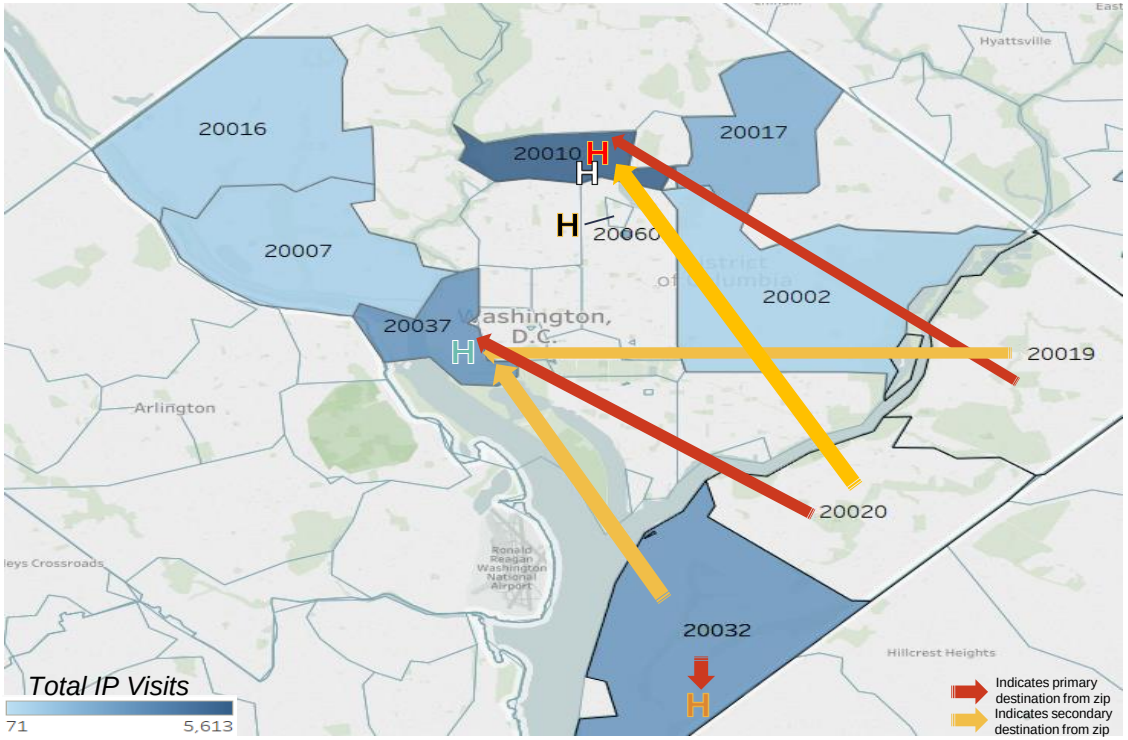
APPROACH AND METHODOLOGY

INPATIENT AND OUTPATIENT TRENDS ACROSS D.C. BY WARDS 7 & 8

Issues	Analytical Approach	Data Source
1 **Key services and preferred destination by PSA residents**	**Inpatient**  **Outpatient**  **Ancillary Services** 	▪ *D.C. Medicaid Claims data 2014 - 2016*
2 **Competitor profiles of acute health systems in D.C.**	▪ Financial and Operational Performance ▪ Key Clinical Services and Market Differentiators ▪ Strategic Direction	▪ *Truven market reports* ▪ *D.C. health system websites*
3 **Framework for replacement facility to be located in Wards 7 and 8**	▪ Strategy ▪ Key services consideration ▪ Organizational structure	▪ *Huron proprietary analysis*

INPATIENT | OVERALL DISCHARGES

WITHIN D.C. PSA MEDICAID BENEFICIARIES IP HOSPITAL PREFERENCES VARY BY ZIP CODES



- Top 5 preferred D.C. hospitals by adult beneficiaries accounted for ~70% of total IP volume.
- Children's National Medical Center ranked 6th overall, but accounted for ~38% of all pediatric PSA Medicaid beneficiaries IP volume.

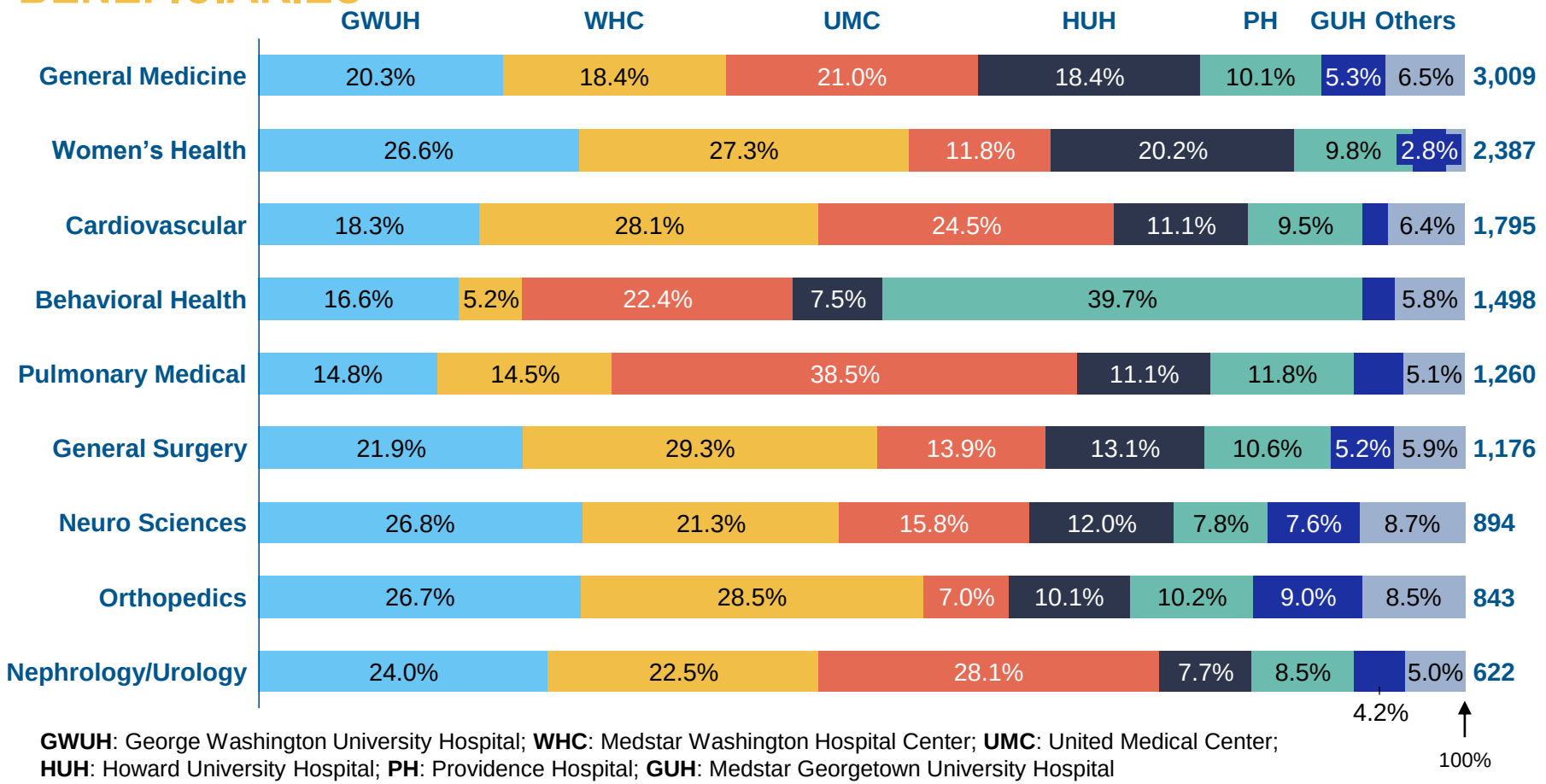
Top 5 hospitals by IP discharges in 2016 (N = 17,186)

PSA - ZIP Code	Medstar WHC H	GWU Hospital H	UMC H	Howard Uni. Hospital H	Children's National H
20019	**1536**	967	443	957	533
20020	745	**803**	726	527	336
20032	829	884	**1285**	600	386

SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

INPATIENT | ADULT: SERVICE LINE MARKET SHARE

UMC RANKED 3RD IN OVERALL DISCHARGES AMONG PSA MEDICAID BENEFICIARIES



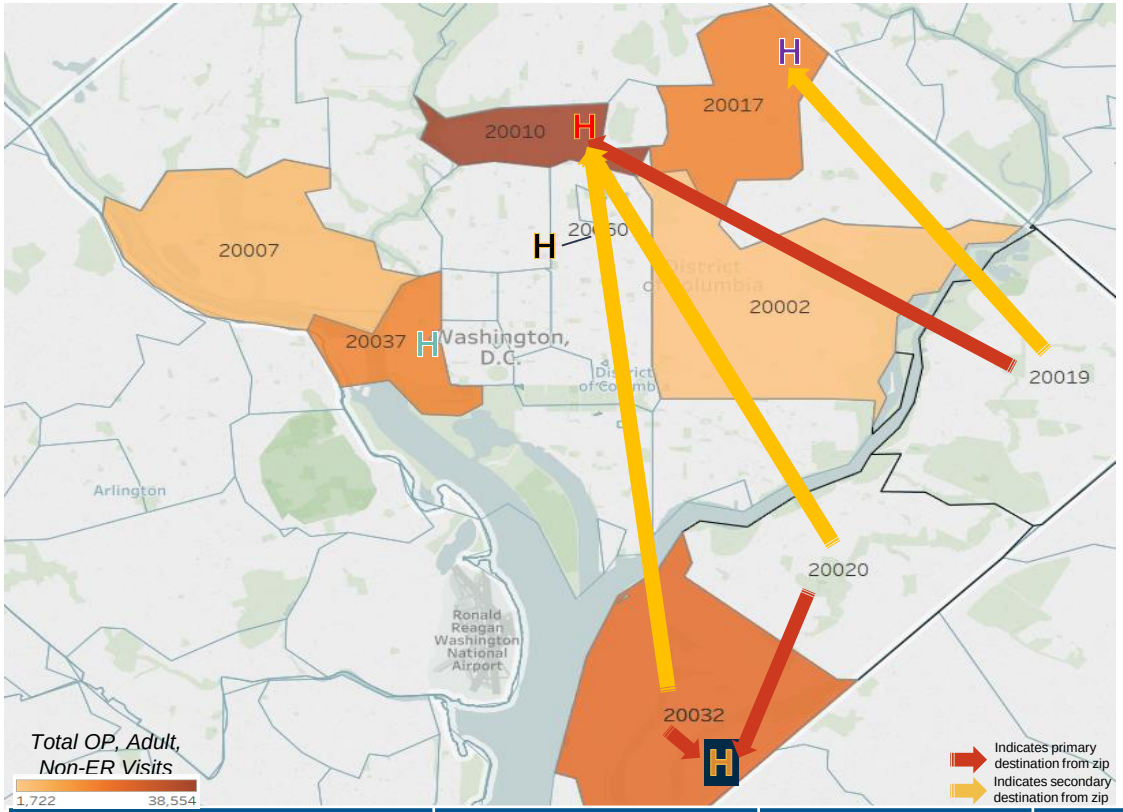
GWUH: George Washington University Hospital; **WHC**: Medstar Washington Hospital Center; **UMC**: United Medical Center; **HUH**: Howard University Hospital; **PH**: Providence Hospital; **GUH**: Medstar Georgetown University Hospital

- WHC is the most competitive of D.C. hospitals for inpatient services among PSA Medicaid beneficiaries, with an overall 22% market share; GWUH is second with 19%. UMC ranked 3rd in PSA with 18% market share.
- WHC led market share in high margin service lines (e.g., Cardiovascular, Orthopedics, Neurosciences, and General Surgery).

SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

OUTPATIENT | ADULTS: OVERALL VISITS

FOR ADULTS, UMC IS THE PREFERRED OUTPATIENT DESTINATION FROM NEAREST 2 OF 3 PSA ZIP CODES



- Overall, Medstar WHC is the preferred destination for OP visits (24% of OP volume) in the PSA, driven by robust utilization from ZIP Code 20019.
- UMC is the preferred OP destination from ZIP Codes 20020 and 20032 but ranks as the secondary preferred destination overall with ~20% of volume.

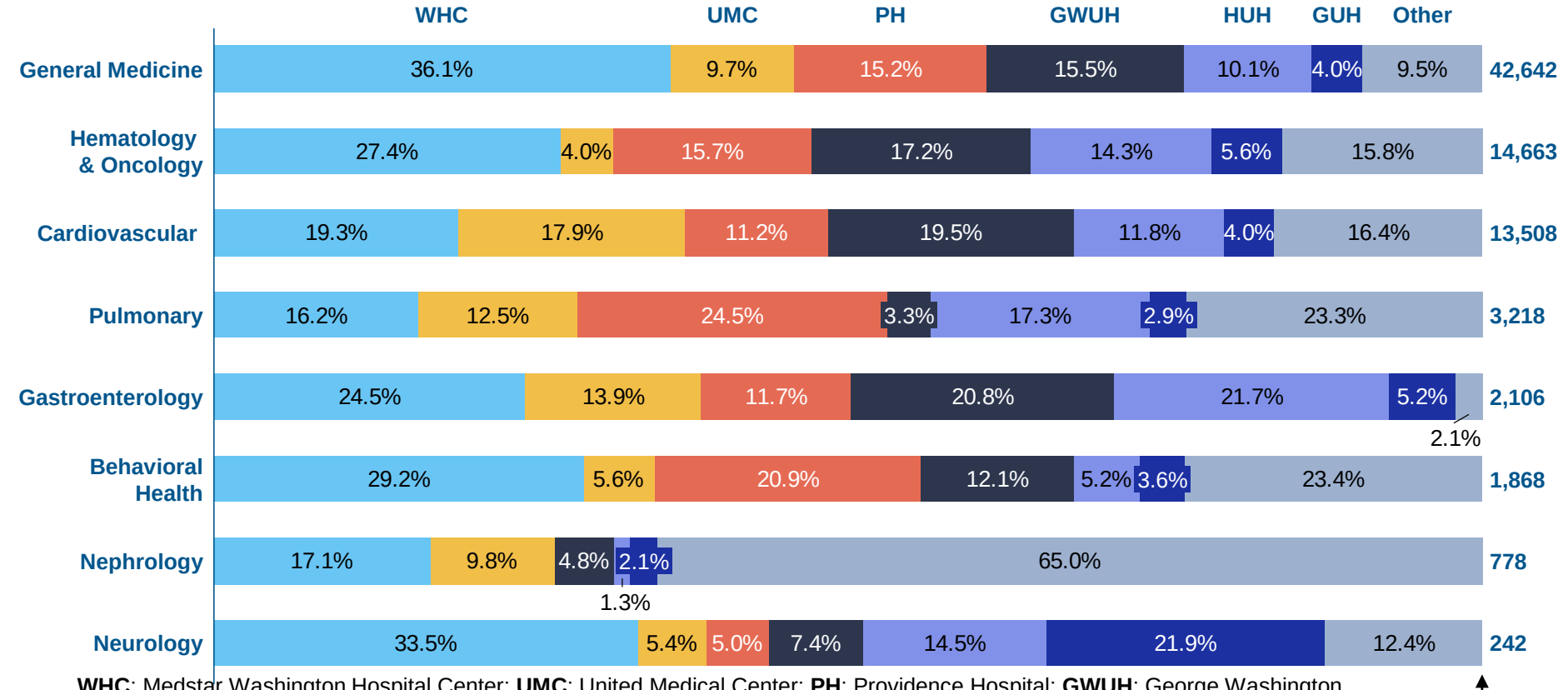
Top 5 hospitals by OP visits

PSA - ZIP Code	Medstar WHC H	Providence Hospital H	GWU Hospital H	Howard Uni. Hospital H	UMC H
20019	12917	9031	6010	4423	3666
20020	6459	2885	4252	2349	6612
20032	6897	3109	4322	2585	10026

SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

OUTPATIENT | ADULTS: MARKET SHARE (MEDICAL)

MEDSTAR WHC IS THE PREFERRED DESTINATION FOR MAJORITY OF OUTPATIENT MEDICAL SERVICE LINES



WHC: Medstar Washington Hospital Center; **UMC**: United Medical Center; **PH**: Providence Hospital; **GWUH**: George Washington University Hospital; **HUH**: Howard University Hospital; **GUH**: Medstar Georgetown University Hospital

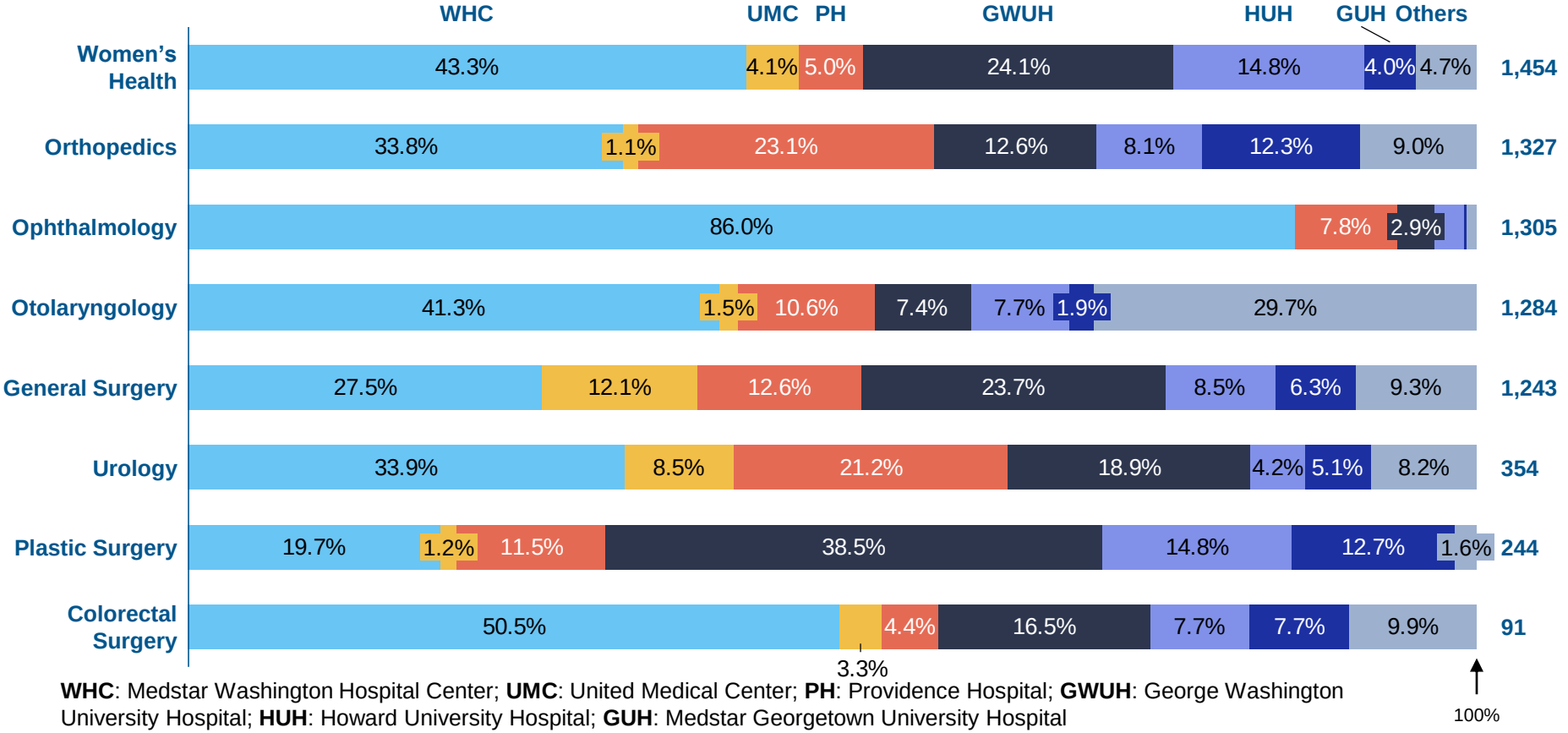
- WHC leads medical outpatient services from PSA Medicaid beneficiaries with 30% market share from the top 8 service lines, and GWUH is second with 16%. UMC ranks 5th in PSA with 10% market share (from top 8 service lines).
- UMC is the preferred destination for outpatient Pulmonary Medicine with 24.5% of market share among PSA residents.

Note: UMC ranked 2nd overall but service line market share likely under-reported due to challenge in mapping ~50% of UMC OP visits to defined service lines categories. However, under reported service lines are likely to be within General Medicine, Pulmonary and Behavioral Health

SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

OUTPATIENT | ADULTS: MARKET SHARE (SURGICAL)

SIMILARLY, MEDSTAR WHC IS THE MOST PREFERRED FOR SURGICAL OUTPATIENT SERVICES EXCEPT FOR PLASTIC SURGERY



WHC: Medstar Washington Hospital Center; **UMC**: United Medical Center; **PH**: Providence Hospital; **GWUH**: George Washington University Hospital; **HUH**: Howard University Hospital; **GUH**: Medstar Georgetown University Hospital

- WHC is the most competitive among D.C. hospitals for outpatient Women's and surgical services among PSA Medicaid beneficiaries, accounting for ~45% of market share. GWUH is second with 15%. UMC ranks 6th in PSA with 3.5% market share for outpatient surgical services.
- UMC's highest market share is in General Surgery (12.1%), ranking fourth among D.C hospitals.

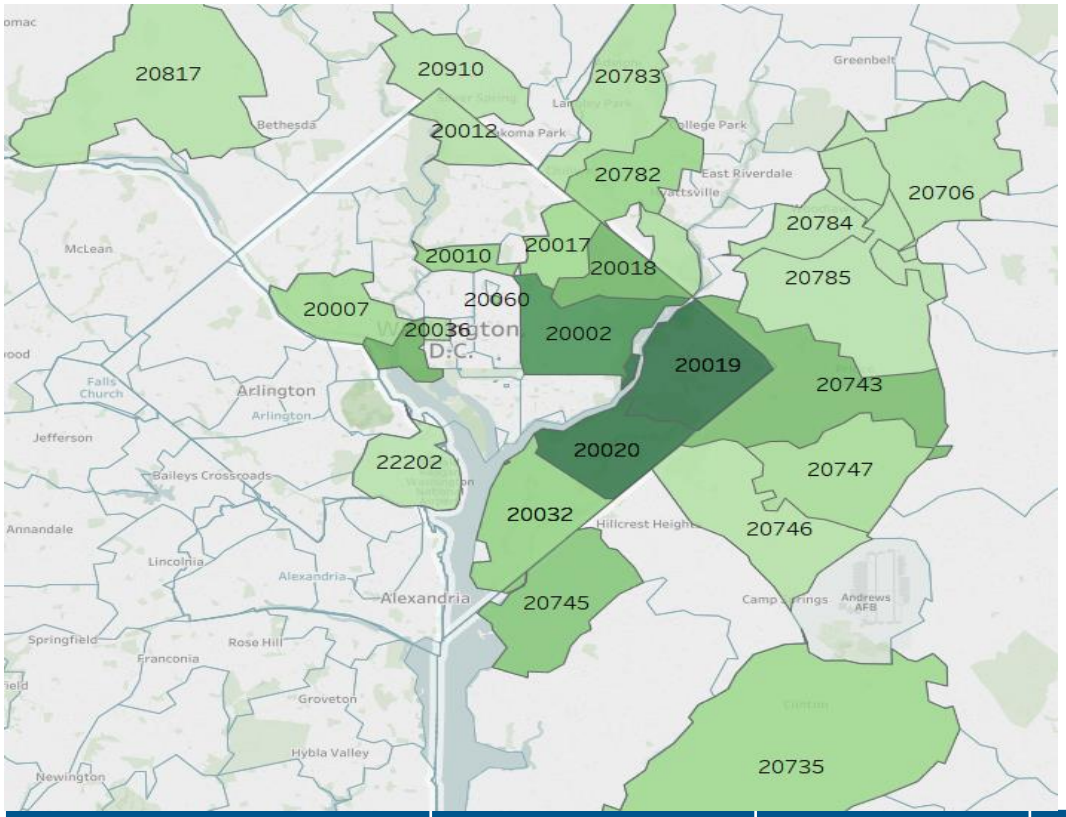
Note: UMC ranks 2nd in overall but service line market share likely under-reported due to challenge in mapping ~50% of UMC OP visits to defined service lines categories. However, under reported service lines are likely to be within medical related service lines such as General Medicine, Pulmonary and Behavioral Health

SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

HURON

DIALYSIS | OVERALL VISITS

~81% OF DIALYSIS VISITS ARE WITHIN D.C.'S DIALYSIS CENTERS



- 81% of hemodialysis utilization occurs within D.C.'s centers, but providers (centers) are more diverse, with the top 5 centers accounting for 50% of market share.
- There are 3 dialysis centers each in ZIP Codes 20019 and 20020, but only 1 in ZIP Code 20032, suggesting an opportunity to decrease outmigration dialysis services.
- DaVita has the largest market share (23%) from PSA Medicaid beneficiaries and has 3 locations in D.C but none within the PSA.

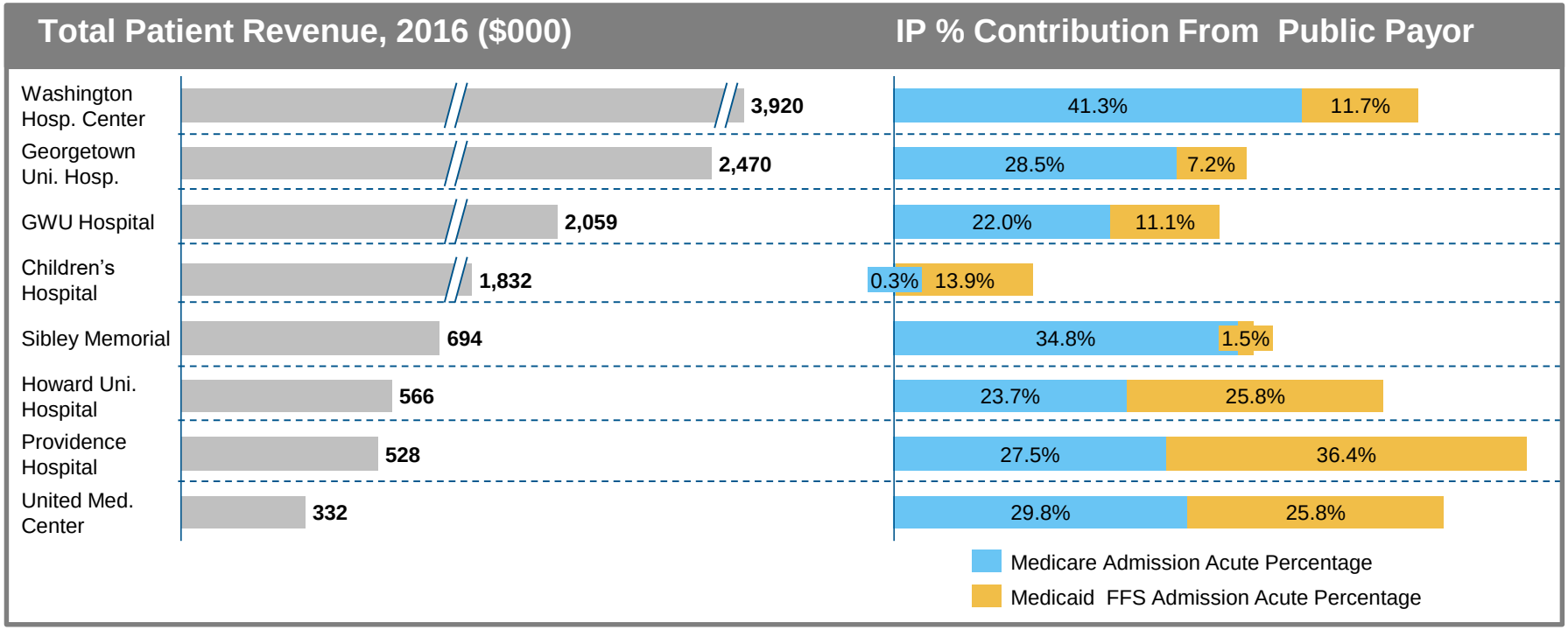
Top 5 Hemodialysis Centers by visits, 2016 (N= 38,398)

PSA - ZIP Code	DaVita Renal Healthcare Inc.	Renal Treatment Ctrs.	GWU Southeast Inc.	Grant Park Dialysis Ctr.	RAI Care Ctrs. SE D.C.
20019	**3926**	2665	835	1718	363
20020	**2746**	145	981	291	560
20032	**1973**	714	1111	366	766

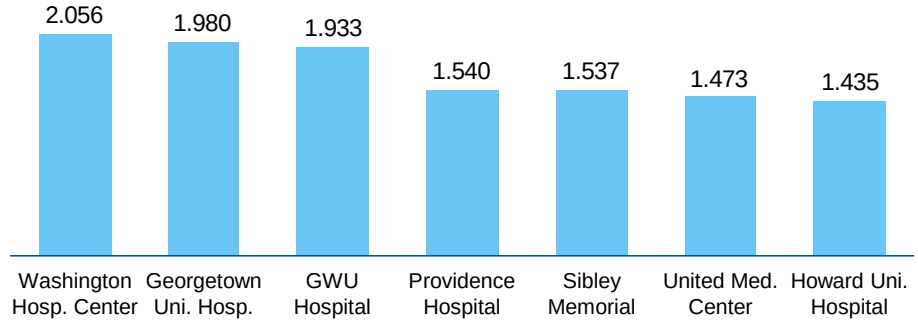
SOURCE:
1. D.C. Medicaid Claims data for Ward 7 & 8 beneficiaries, 2014, 2015 and 2016
2. Huron Analysis

HEALTH SYSTEMS PROFILE | OVERVIEW

D.C. HEALTH SYSTEMS HAVE VARIABLE LEVELS OF PUBLIC PAYOR CONTRIBUTION TO THEIR TOTAL REVENUE



Adjusted CMI, D.C. Hospitals, 2016



In 2016, Providence Hospital had the largest contribution of Medicaid FFS (and overall public payor contribution) as a percentage of IP revenue, but also has the lowest expense per adjusted patient day in D.C.

SOURCE: Truven Analytics, Hospital Annual Report

NEW FACILITY | STRATEGY

Change in residents' perception of replacement facility required in order to address effectively outmigration in inpatient and outpatient services.

- Key improvements residents want to see include[1]:
  - Broad array of services offered on campus, including more specialty services
  - Better physical condition of facilities
  - Improvement in quality of care and patient experience
  - Integration into a larger health care system

Key strategic areas for consideration:

- Alignment of service mix offerings to current and projected demand
  - Exit non-core services and grow profitable volume in target service lines.
- Develop clinical excellence in service offerings
  - Achieve top clinical metrics and create better patient experience across selected service areas
- Develop and expand access points to new facility
  - Develop robust referral / affiliation network with other providers and FQHCs
- Ensure financial viability for new facility
  - Align with payors to attract commercially insured lives from PSA and SSAs
  - Renegotiate contracts, including with D.C. Medicaid

1) Based on prior survey.

NEW FACILITY | STRATEGY

CASE STUDY: DOCTORS COMMUNITY HOSPITAL

Overview

- **Doctors Community Hospital** is a medium-sized general medical and surgical hospital founded in 1975; no affiliation to any major health system or AMC.
- **Staffed beds: 163**
- **Utilization: 87%**

Financials

- Total Patient Revenue, 2016**: $226M**
- EBITDA margin**: 9.9%**
- Net income**: $1.4M**

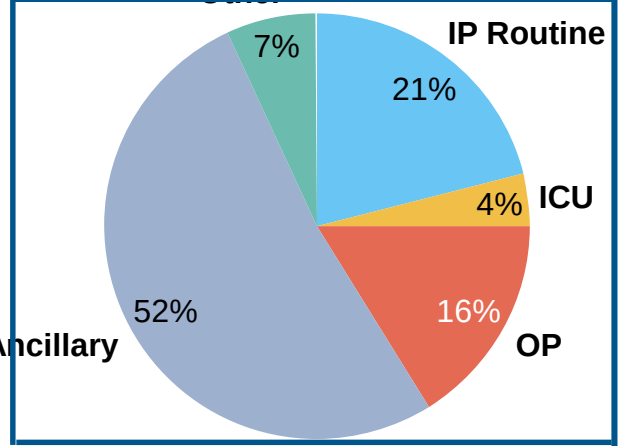
Core Services

- Inpatient Routine Services: **21%**
- Intensive Care Unit: **4%**
- Outpatient services: **16%**
- **Ancillary services: 52%**
- Other: **7%**

Payor Mix

- % Revenue that is public payor: **58%**
- **Medicare (52%) / Medicaid (6%)**

Revenue by Core Services



Differentiation

- Strong reputation for quality (numerous awards including US News and World Report High Performing Hospitals in COPD and Heart Failure 2016-2017).
- Doctor-led hospital with strong physician base.

1. 52% of Ancillary services revenue is driven by inpatient demand.
2. Ancillary services at DCH includes Laboratory, Diagnostic Radiology & Imaging Center, and Rehabilitation and Patient Care center.

SOURCE: Case study based on publicly available information from Electronic Municipal Market Access (EMMA) system, Definitive Healthcare, Doctors Community Hospital website

3.4

CLIN 4 – DEFINING AN OPTIMAL DESIGN

DESIGN OPTIONS | SUMMARY

Design Options	Services and Footprint	Assumed Operational Risk	Physician Alignment
A **Conventional Facility**	• Comprehensive service offering • 150+ acute beds	Full	Multiple models likely
B **Specialty Hospital (e.g. Women's and Children's facility)**	• Limited IP services (institute/COE) • 50-75 acute beds	Partial/Shared	Traditional PHO
C **Integrated Medical Campus with Ambulatory Pavilion**	• Comprehensive IP service • Focus on care demand shifts to OP/ambulatory • 100-150 acute beds	Partial/Shared	Fully-integrated
D **Ambulatory and Ancillary Services Medical Mall** with minimal inpatient footprint	• Comprehensive ambulatory and ancillary services in co-located medical mall • 25-50 acute beds	Low/Transferred	MSO, PHO, and Independent affiliations

Alternate options (suggested by potential partners)

- **Ambulatory center only, with ED:** Comprehensive OP primary and specialty physician and ancillary services with ED in medical mall but no acute care
- **Hospital Management Contract:** Management of medical center with IP and OP services contracted to 3rd party operator, but D.C. maintains ownership and overall accountability for facility

HURON

DESIGN OPTIONS | ASSESSMENT OF STRATEGIC FIT (1/2)

Design Options		Community objectives	Partner objectives	District objectives	Action/ Comment
A **Conventional facility**	**Pros**	▪ Broad array of services			Do not recommend
	Cons	▪ Difficult to differentiate from current reputation of existing facility regarding patient experience and clinical outcomes ▪ Not aligned to desire for integration with larger health system	▪ Standalone facility will find it difficult to be competitive in current environment ▪ Large IP footprint reduces likelihood for operator to effectively control operational cost due to unfavorable payor mix	▪ Not aligned to cost effective health care delivery system due to high IP footprint ▪ Likely to be a challenge for facility to operate free of continual subsidy from D.C.	
B **Specialty Center (e.g. Women & Children's facility)**	**Pros**	▪ Access to specialized care for targeted services	▪ Operator has potential to differentiate and position facility as a destination center ▪ Operator can achieve financial viability by attracting more commercial patients from secondary service areas through differentiation	▪ High potential for facility to operate free of subsidy from D.C.	Do not recommend
	Cons	▪ Limited services do not address the broad service need for residents in PSA ▪ Access disparities will continue for majority of residents in D.C.		▪ Not aligned to comprehensive delivery system to address community needs	

DESIGN OPTIONS | ASSESSMENT OF STRATEGIC FIT (2/2)

Design Options		Community objectives	Partner objectives	District objectives	Action/ Comment
C **Integrated Medical Campus**	**Pros**	▪ Broad array of primary and specialty services aligned to community needs ▪ Positive reputation as facility will be branded to a larger and well managed health system ▪ Easier access to non hospital related services in medical campus	▪ Reduced IP footprint increases likelihood for operator to effectively control operational cost ▪ Ambulatory pavilion provides lower cost structure and strong patient referral source to acute care facility ▪ Increased overall patient care coordination ▪ Flexibility to deploy physicians in a fully integrated model	▪ Delivers comprehensive health care delivery system to residents and reduces access disparity ▪ Higher potential for facility to operate free of continual subsidy from D.C.	Recommend
	Cons		▪ Assumes higher operational risk	▪ Difficulty in finding preferred partner	
D **Ambulatory and Ancillary Services Medical Mall**	**Pros**	▪ Broad array of OP primary and specialty services aligned to community needs ▪ Retail styled access to health care in medical campus potentially improves patient experience	▪ Lower cost structure and strong patient referral source to parent acute care facility ▪ Multiple independent operators in medical mall reduces operational risk for any one provider	▪ High potential for facility to operate free of subsidy from D.C.	Do not recommend
	Cons	▪ Limited IP capabilities not aligned to broader community needs		▪ Not aligned to comprehensive delivery system to address community needs	

OPTIMAL SERVICE MIX | KEY SERVICE LINES

SERVICE LINES WITH HIGH CARE DEMAND WILL BE PRIORITY

- Service Lines with high projected demand across both inpatient and outpatient environments should be considered priority opportunity areas for the new facility
- Relative demand is high across most outpatient services
- While Normal Newborns, Neonatology, and Women's Health show strong relative demand (volume), these services are not projected to grow over the next ten years
- Final determination of service lines should leverage potential partner strengths

Key Service Lines	Inpatient services	Outpatient / Ambulatory services
General Medicine		
Normal Newborns		
Behavioral Health		
Women's Health		
Neurosciences		
Nephrology/Urology		
Cardiovascular		
Pulmonary		
General Surgery		
Orthopedics		
Neonatology		
Oncology		
ENT		
Ophthalmology		
Emergency Medicine		
Radiology		
Labs		
Hemodialysis		
Physical & Occ. Therapy		

Service lines with high projected demand

Service lines with moderate projected demand

Services lines or ancillary services with minimal projected demand

Using D.C. Medicaid claims data as a reference, pediatric age group (0-17 years) will account for 15 – 20% of overall demand across service lines and sites of care

SOURCE: Truven analytics, D.C. Medicaid Claims data, Huron Analysis

HURON

OPTIMAL SERVICE MIX | FACILITY DESIGN

7 LEVERS USED TO MODEL DISTINCT MARKET SCENARIOS

- Seven key modeling levers were used to attribute potential volume and revenue to the new facility, as well as project capacity requirements.
- These levers were informed by market-based projections, analysis of D.C Medicaid claims data for Wards 7 and 8 residents, and analysis of utilization data from UMC.

	Lever	Focus
1	Payor Mix	Based on market projections for years 2022 and 2027
2	Allocation of Utilization by Payor Mix	Anticipated utilization burden from different insured population segments
3	Reimbursement	Anticipated payor reimbursement based on percent of Medicare
4	Service Mix	Based on market projections; care demands meeting sustainable threshold
5	Market Share	By service line; percent of primary and secondary market the new facility will attract
6	Bed Utilization	Anticipated occupancy rate
7	OR Throughput	By service line; operating hours, procedure and turnover time

OPTIMAL SERVICE MIX | FACILITY DESIGN

VARYING MARKET SHARE ASSUMPTIONS USED TO MODEL SCENARIOS

Market Share Assumptions

Low Market

- Base market share built upon UMC's historical market share from D.C. Medicaid claims data
- UMC's share adjusted up based on expected additional demand from Medicare utilization not captured in claims analysis
- Additional moderate adjustment to account for new brand and location capital

Medium Market

- Includes share from Low Market Scenario
- Adjusted up under assumption of reduced number of hospital providers in D.C.
- Assumes a shift of market share from Wards 6, 7, and 8 to new facility

High Market

- Includes share from Medium Market Scenario
- More aggressive upward adjustment to account for new brand and location capital
- Assumes a higher shift of market share from Wards 6, 7 and 8

Forecasting total market share requires consideration of the entire market (all payors), industry demand, and drivers of market share, including brand capital, quality, reputation, and other qualitative factors.

OPTIMAL SERVICE MIX | REVENUE POTENTIAL

SUMMARY OF PROJECTED REVENUE

2022 Projections

Market Capture/ Share Assumptions	Inpatient	Outpatient	ED	Total
Low Market	$83.6M	$33.6M	$20.6M	$137.8M
Medium Market	$106M	$44.7M	$23.8M	$174.5M
High Market	$121M	$51.7M	$27.6M	$200.3

2027 Projections

Market Capture/ Share Assumptions	Inpatient	Outpatient	ED	Total
Low Market	$88.5	$37.0M	$22.8M	$148.3M
Medium Market	$112M	$49.1M	$26.2M	$187.3M
High Market	$128M	$56.9M	$30.5M	$215.4M

- 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.
- Prior to finalizing these materials, analysis will be presented to inform D.C.'s understanding of scaling and stabilization periods, likely margins based on market and like-facility comparisons, and other variables informing projections of revenues vs. cost and break-even operating periods.

OPTIMAL SERVICE MIX | REVENUE POTENTIAL

REVENUE POTENTIAL PROJECTED TO RANGE BETWEEN $148 - $215M IN 2027 FOR IP AND OP SERVICES IN NEW FACILITY

- Conservative revenue estimates of $148M in 2027 for new facility compares to FY2016 operating revenues of $120M of existing UMC **(~25% increase), despite significantly smaller IP footprint**[1].
- Projected revenues **assume new facility has more efficient operations** for all market share capture scenarios.

Low Market – 2027 Projection

6,954 Total Discharges	751K OP Billed Procedures	56K ER Visits	$148M Total Revenue	96 Acute Beds Assumed

Medium Market – 2027 Projection

8,796 Total Discharges	1.00M OP Billed Procedures	65K ER Visits	$187M Total Revenue	121 Acute Beds Assumed

High Market – 2027 Projection

10,033 Total Discharges	1.14M OP Billed Procedures	76K ER Visits	$215M Total Revenue	138 Acute Beds Assumed

Note:
Current projections are based on expected market demand by residents in Wards 7 and 8; and are subject to change depending on bed size and service line preferences of selected partner(s) and how they want to position the new facility to meet their overall (and District's) objectives.

1. UMC has 234 licensed beds and currently staffs135 beds.
2. 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

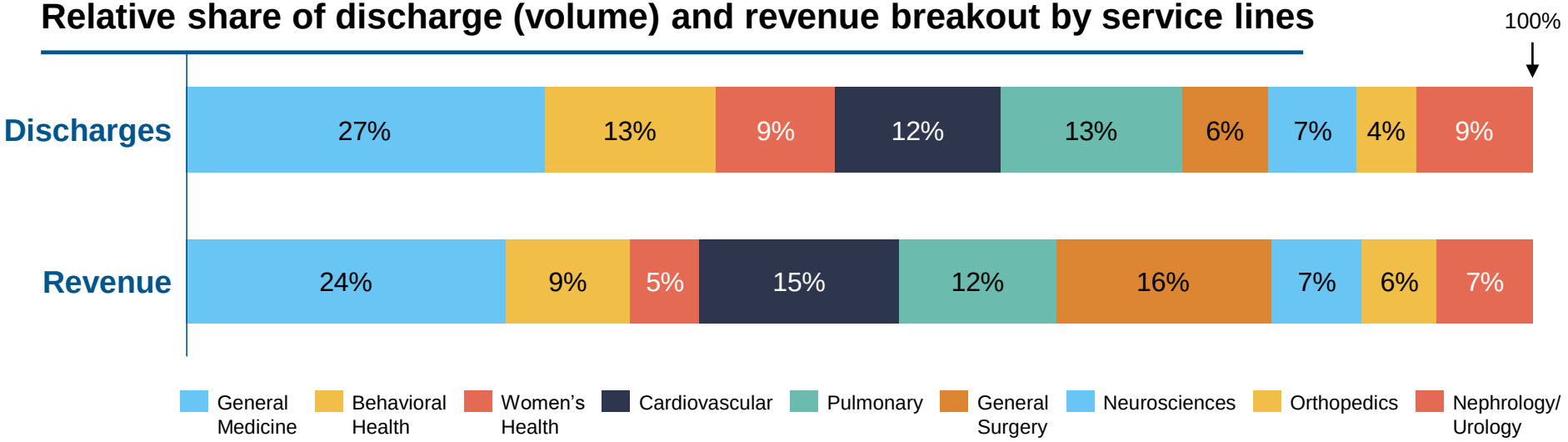
SOURCE: Truven analytics, Huron Analysis, UMC Audited Financials, FY2016

HURON

OPTIMAL SERVICE MIX | INPATIENT OPPORTUNITY

9 KEY SERVICE LINES EXPECTED TO DRIVE INPATIENT REVENUE OPPORTUNITY

Relative share of discharge (volume) and revenue breakout by service lines



Key Takeaways

- IP revenue projections for new facility focused on services from 9 key service lines.
- **General Medicine** will drive the greatest proportion of revenue and utilization but **General Surgery, Cardiovascular, Orthopedics** are expected to produce higher revenue return relative to utilization.
- Final determination of service lines should leverage potential partner strengths.

SOURCE: Truven analytics, Huron Analysis

HURON

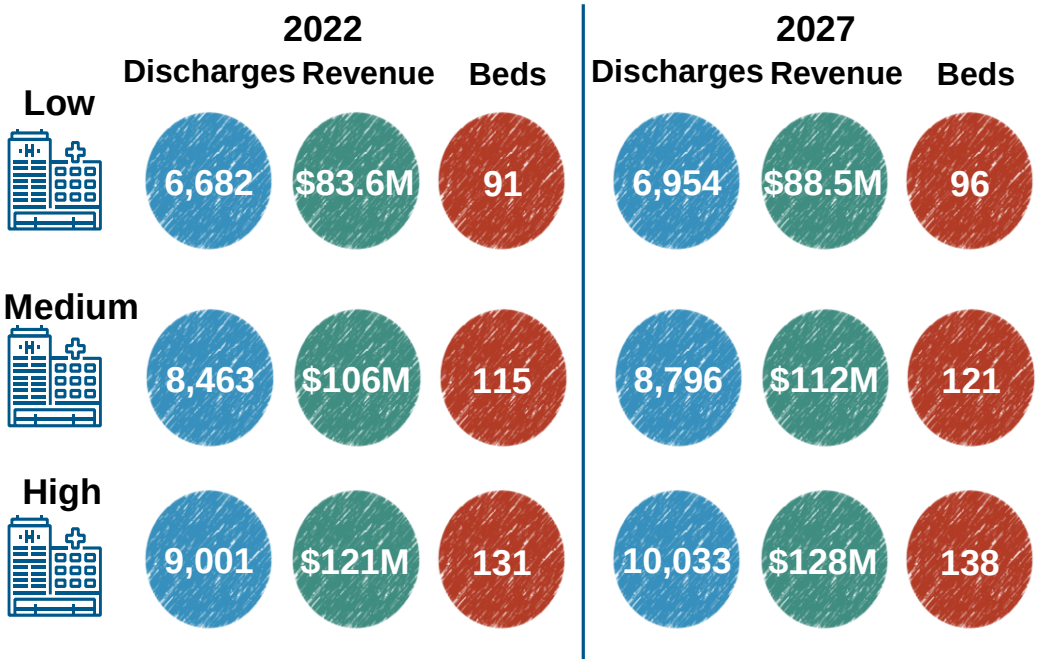
OPTIMAL SERVICE MIX | INPATIENT OPPORTUNITY

96 – 138 BEDS REQUIRED IN NEW FACILITY IN 2027 DEPENDING ON LIKELY MARKET SCENARIO

Bed size assumptions

- Low market scenario assumes NewCo maintains current facility discharge volumes but gains operational efficiency and higher utilization.
- Medium market scenario assumes low market scenario with increased potential market share capture.
- High market scenario assumes medium market scenario and additional brand capital of new facility as well as new provider reputation driving stronger IP demand. Not a likely scenario at the start of NewCo.

Projected IP utilization, revenues and expected bed needs for new facility across 3 market scenarios



SOURCE: Truven analytics, Huron Analysis

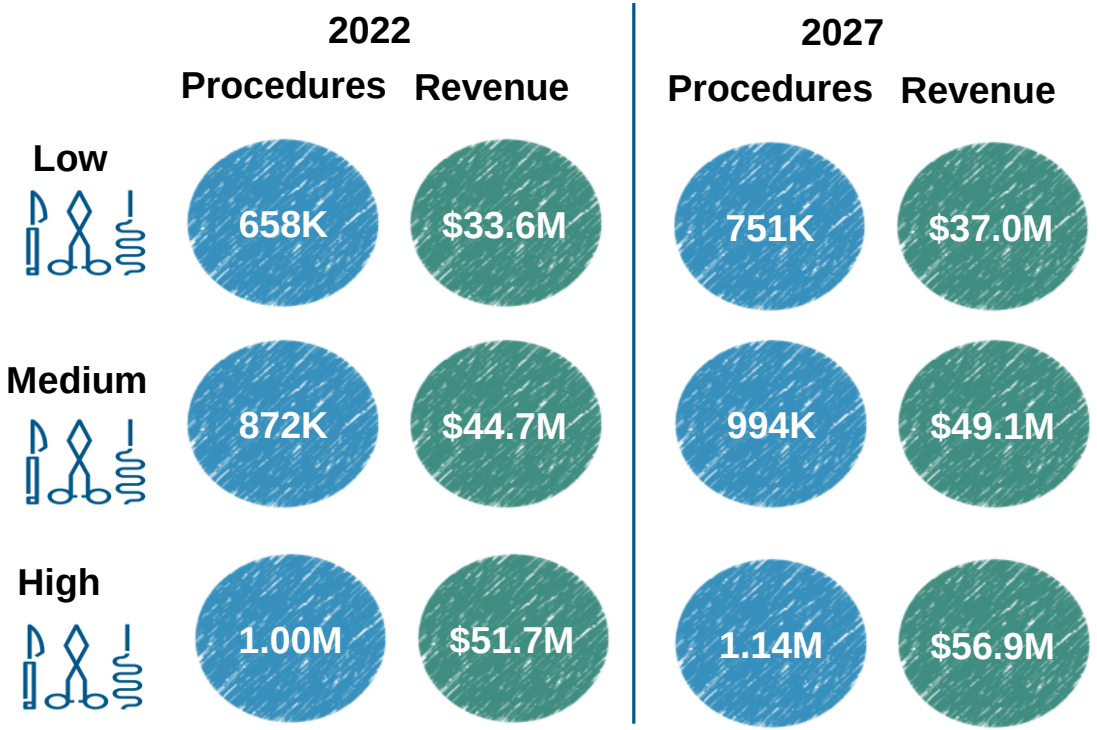
OPTIMAL SERVICE MIX | OUTPATIENT OPPORTUNITY

VOLUME AND REVENUE MIX OVERVIEW

Key Takeaways

- OP revenue projections range from $33.6 - $51.7M in 2022 with potential for ~10% revenue growth in 5years.
- New facility brand capital, breadth of primary and specialty services, and ease of access to ancillary services likely to drive OP demand to mirror medium to high market scenarios.
- Fully integrated physician alignment model that ensures the presence of a breath of specialty services in ambulatory center is critical to achieve medium to high market scenarios.

Projected OP utilization and revenues for new facility across 3 market scenarios

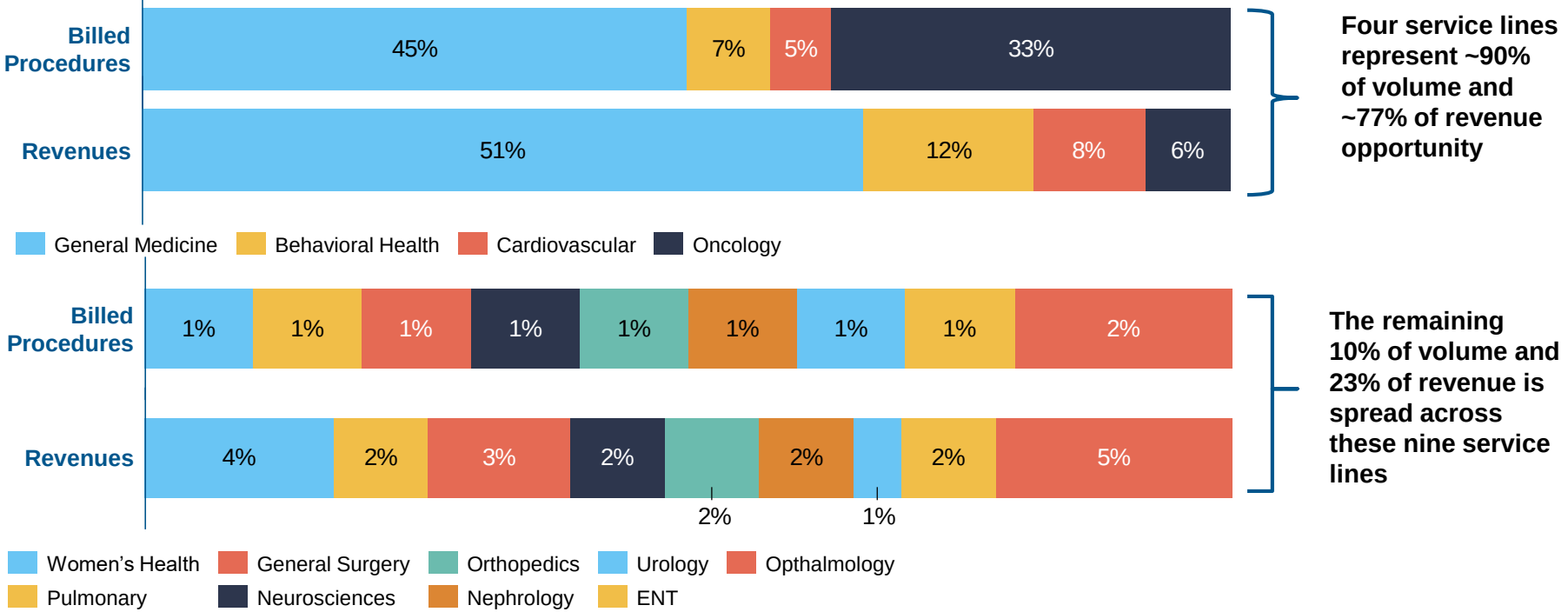


SOURCE: Truven analytics, Huron Analysis

OPTIMAL SERVICE MIX | OUTPATIENT OPPORTUNITY

13 SERVICES LINES WILL DRIVE OUTPATIENT REVENUE ACROSS AMBULATORY SITES OF CARE

Relative share of billed procedures and revenue breakout by service lines



Four service lines represent ~90% of volume and ~77% of revenue opportunity

The remaining 10% of volume and 23% of revenue is spread across these nine service lines

Key Takeaways

- OP revenue projections from 13 service lines compared to 9 service lines from IP, indicating broader demand for ambulatory services.
- Similar to IP, **General Medicine** will drive the greatest proportion of OP revenue and utilization.
- Demand for **Oncology, ENT, and Ophthalmology** are robust only in ambulatory settings.

SOURCE: Truven analytics, Huron Analysis

HURON

OPTIMAL SERVICE MIX | ER AND URGENT CARE

13-27% OF ER VISITS COULD POTENTIALLY BE STEERED TO URGENT CARE SETTINGS WITH APPROPRIATE BEHAVIORAL MODIFICATION

- 13-27% of ER visits – typically low acuity cases - could be effectively managed within urgent care settings[1].
- Presence of urgent care clinics alone may not shift ER volume[2], therefore initiatives to modify residents perception and behavior towards ER utilization will be needed to achieve volume steerage from ER to urgent care clinics.

Projected ER utilization and revenue across 3 market scenarios

	Low Market		Medium Market		High Market	
	2022	2027	2022	2027	2022	2027
ER Visits	51,589	56,952	59,455	65,618	69,089	76,196
Revenue Estimate	$20.6M	$22.8M	$23.8M	$26.2M	$27.6M	$30.5M

Urgent Care Demand (2027, Total Market)

PSA	SSA-DC	SSA-MD
1,245	851	1,665

Total market demand projections for urgent care is limited in the Wards 6, 7, and 8, due to low historical utilization (lack of adequate access), however demand for urgent care services is projected to grow 146% between 2017 and 2027.

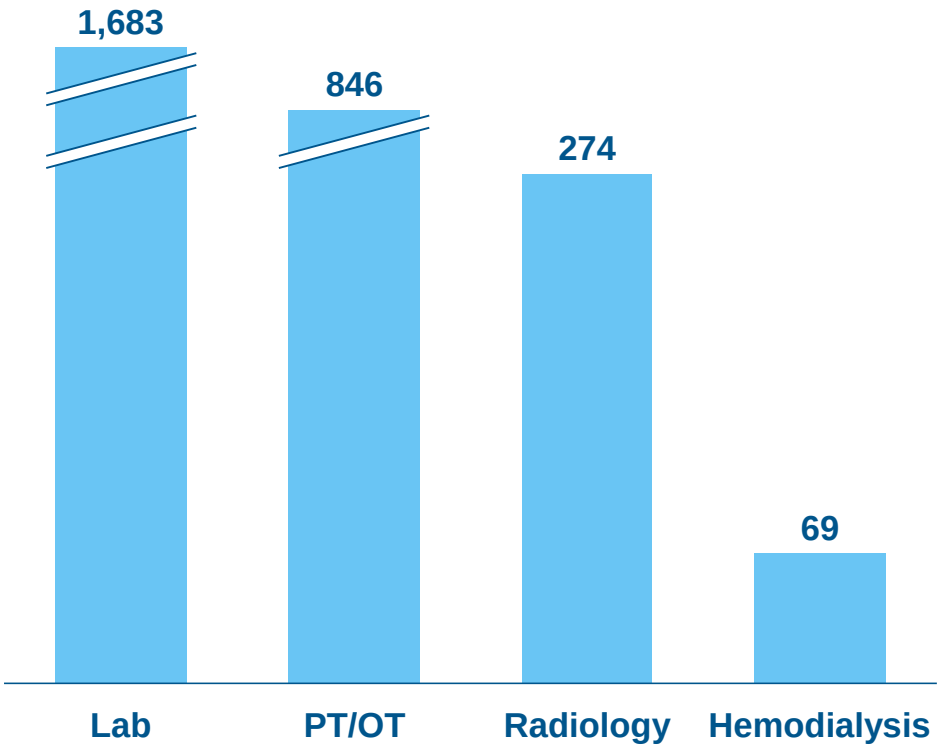
1. Health Affairs – 2012
2. Annals Emergency Medicine – 2016
3. Truven analytics
4 Huron analysis

OPTIMAL SERVICE MIX | ANCILLARY UTILIZATION

OPPORTUNITY FOR ANCILLARY SERVICES TO STRENGTHEN FACILITY REPUTATION AS A INTEGRATED MEDICAL CAMPUS

- PSA demand for ancillary services remains strong with at least 18% growth expected from 2017 to 2027.
- Surgically-driven ancillary demand accounts for 20% of projected total billed procedures for 2027.
- Other outpatient demand, realized in physician offices, independent imaging centers, independent labs, and other sites, accounts for ~75% of all ancillary outpatient demand.
- Provision of robust services within NewCo creates opportunity to enhance facility reputation as an integrated medical campus (one stop shop).

Projected billed procedures from ancillary services, CY 2027 (000s)



Lab = Laboratory, PT/OT = Physical and Occupational Therapy
Radiology includes Diagnostic Radiology, CT scan and MRI at 82%, 10% and 8% of projected volumes respectively.

OPTIMAL SERVICE MIX | SNF OPTIONS

IMPROVEMENT OPPORTUNITIES LIKELY TO BE ACHIEVED BY DIVESTING OPERATIONS TO THIRD PARTY

	Option 1: Divest	Option 2: Keep In-house	Option 3: Divest and Partner
Pros	▪ Removes SNF at existing UMC facility that is currently unprofitable due to high operational cost and inefficient patient management ▪ Opportunity for new owner to provide more efficient management and better patient care experience ▪ Opportunity to reverse negative facility reputation attributable to existing SNF ▪ Aligned with national trends of increasing closures of hospital based SNF due to negative operating margins	▪ N/A	▪ Pros in Option 1 (Divest) ▪ Greater opportunity for NewCo to collaborate in standardizing protocols at SNF, control cost and improve 30-days readmission metrics
Cons	▪ Loss of control to potentially influence 30-day readmission metrics. Collaboration between provider and SNF operator on clinical metrics should be a priority area for consideration in selecting new SNF operator	▪ Highly challenging to transform SNF to financial viability because it will require complete reorientation of existing services, staff and systems ▪ Most patients at current facility are “custodial”, not at a level requiring skilled care but there aren’t supportive home services to allow for necessary discharge ▪ Difficulty to attract experienced third party operators without substantial change in SNF leadership and practices	▪ Potentially more complex to execute operationally, depending on the level of partnership

“Divest” assumes location of new SNF will be outside of NewCo’s footprint. Ideal new location to be considered in collaboration with potential acquirer / third party operator.

HOSPITAL REPLACEMENT| COST ANALYSIS

TOTAL PROJECT COST RESEARCH FINDINGS

- Huron researched total project costs for “greenfield” hospital campuses and targeted the eastern part of the United States and urban locations whenever possible. Total project cost includes all expenses associated with the construction of the hospital as summarized below:

Land Purchase	Site Preparation	Permits & Certifications
Building Construction	Architect/Engineering Fees	Contingencies
Information Technology	Movable Equipment & FFE	Capital & Financing Costs

- We relied on several sources to obtain hospital construction costs including Definitive Healthcare, Certificate of Need applications, Marshall Valuation Service and articles online. We discovered ten “greenfield” construction projects and placed primary emphasis on four hospitals located in Maryland and three located in New Jersey. We provided a detailed write-up for the hospitals which are located at the end of this presentation.
- The District has also secured the services of Healthcare Building Solutions (“HBS”) to asset with this analysis.

HOSPITAL REPLACEMENT| COST ANALYSIS

TOTAL PROJECT COST RESEARCH FINDINGS

- The following table illustrates the location, total project cost, number of beds, square feet, square feet per bed, cost per bed, cost per square foot and expected completion date for each of the new hospital sites included in our analysis:

Hospital	State	Total Project Cost	Beds	Square Feet	SF / Bed	Cost / Bed	Cost / SF	Total Project Cost Less Land	Completion
Holy Cross Germantown Hospital	MD	$ 202,000,000	93	237,000	2,548	$ 2,172,043	$ 852	$ 194,253,984	2015
Washington Adventist White Oak Hospital	MD	330,829,524	170	427,662	2,516	1,946,056	774	319,829,524	2019
University of Maryland Shore Medical Center at Easton	MD	349,904,500	119	354,643	2,980	2,940,374	987	306,904,500	2022
Prince George's Regional Medical Center	MD	555,350,000	205	595,695	2,906	2,709,024	932	543,000,000	2021
The Valley Hospital	NJ	752,608,000	372	910,000	2,446	2,023,140	827	NA	2023
Virtua Memorial Hospital of Burlington County	NJ	527,215,100	383	670,000	1,749	1,376,541	787	NA	2022
Inspira Medical Center - Mullica Hill	NJ	349,000,000	204	467,000	2,289	1,710,784	747	NA	2019
Dell Seton Medical Center	TX	310,000,000	211	517,000	2,450	1,469,194	600	NA	2017
Houston Methodist Woodlands Hospital	TX	328,000,000	193	470,000	2,435	1,699,482	698	NA	2017
Eskenazi Hospital	IN	754,000,000	315	1,200,000	3,810	2,393,651	628	NA	2014

HOSPITAL REPLACEMENT| COST ANALYSIS

TOTAL PROJECT COST RESEARCH FINDINGS

- The 10 hospitals displayed in the table on the preceding page present the following total cost per bed and total cost per square foot metrics:

Metric:	Cost per Bed	Cost per SF
Minimum:	$1,376,541	$600
Maximum:	$2,940,374	$987
Mean:	$2,044,029	$783
Median:	$1,984,598	$780

- If we consider the seven hospitals located Maryland and Jersey, the total cost per bed and total cost per square foot is as follows:

Metric:	Cost per Bed	Cost per SF
Minimum:	$1,376,541	$747
Maximum:	$2,940,374	$987
Mean:	$2,125,423	$844
Median:	$2,023,140	$827

HOSPITAL REPLACEMENT| COST ANALYSIS

TOTAL PROJECT COST RESEARCH FINDINGS

- Lastly, if we consider only the four hospitals located in Maryland, metrics for total cost per bed and total cost per square foot are as follows:

Metric:	Cost per Bed	Cost per SF
Minimum:	$1,946,056	$774
Maximum:	$2,940,374	$987
Mean:	$2,441,874	$886
Median:	$2,440,534	$892

- As illustrated in the preceding tables, the average and median total cost per bed and total cost per square foot for Maryland is higher compared to costs for hospitals in other localities included in this analysis. Location has a significant impact on total projects costs along with construction class and quality, LEED certification, technology, level of services and square feet per bed. The trend toward bigger patient rooms is starting to reverse with more providers seeking to reintroduce smaller patient rooms to contain costs.

HOSPITAL REPLACEMENT| COST ANALYSIS
TOTAL PROJECT COST RESEARCH FINDINGS

- In addition to the items mentioned on the preceding pages, the following can also have a significant impact on hospital construction costs:

Climate	Soil type and conditions	Labor market	State and local planning / zoning requirements
Seismic zoning and requirements	Subterranean conditions	Local wage market	Material shortages or abundances
Wind loading	Site congestion and density	Union labor cost	Global issues such as blockades, embargos, trade restrictions, etc.

- It is also important to note the trend of rising construction costs as evidenced by total project costs for hospitals to be completed over the next few years compared to total project costs for hospitals recently completed.

MARGIN POTENTIAL

Within the DC Market

- Because of the variability of facility types, operating models, footprints, reimbursement structures, payor mix, and care delivery approach, there is no comparative line to be drawn between existing facilities and the proposed new facility.
- Margin opportunity exists in the market, but is dependent upon lowering operating costs and regaining market share within the primary service area.

Among Like-Facilities

- Facilities with smaller overall footprints and less focus on high-acuity inpatient care show significantly lower operating costs.
- Smaller facilities evaluated in this analysis that prove profitable are often 1) integrated with larger delivery systems to support referral paths and drive efficiency through shared services, and 2) maintain academic affiliations to support staffing and the physician enterprise.
- The margin range of these facilities does not have as high of an upside, however is more consistent, with fewer facilities experiencing negative margins over the span analyzed

EBITDA Margin Range	
Low	(-4)-1%
Med	3-6%
High	10+%

Low	(-2)-2%
Med	3-7%
High	8-10%

Audited Financials sourced from EMMA MSRB, GuideStar, and/or DACBond, when available. Additional data sourced from 2016 Hospital Cost Report. Information not deemed credible or consistent (from Cost Report) omitted if data not available elsewhere.

HURON

PROFITABILITY & STABILIZATION

Stabilization Considerations

Based on current and projected market conditions, the District's ongoing support to a new facility will depend on three primary factors:

- Degree to which the new facility can **recapture share of demand in the primary service area**, and become the destination for care for Ward 7 and 8 residents
- Degree to which the facility can be operated efficiently, with emphasis on **reduction in utilization and cost of care**
- Degree to which the new facility can **orient around a broader care delivery system,** with emphasis toward managing effective utilization and decreasing the burden of delivering primary care within a hospital environment

Additional factors influencing degree of profitability and stabilization timeline:

1. Type of operator (profit, not-for-profit)
2. Brand capital of new facility (via operator's brand and/or new facility name)
3. Payor contract diligence (frequent evaluation; avoidance of evergreen contracts; adopting risk)
4. Use of shared services and integrated arrangements for operational support (e.g., supply chain, clinical staffing, etc.)

PROFITABILITY & STABILIZATION

Major Operational Cost Drivers

- Salaries and Employee Benefits
  - Physician Recruitment
- Services and Supplies
  - Interim Management during construction and operational ramp
  - IT systems, IT project management and systems implementation
  - Legal, Audit
- Non-management fiscal and admin services
- Medical Supplies
- Community Health Engagement

Other Cost Drivers

Fixed Assets

- Capital Equipment (Medical)
- Capital Equipment (Information Technology)
- Facilities and Equipment Procurement/Commissioning

Stabilization Risks

- No improvement in attributable payer mix
- No investment in primary delivery system, beyond new facility
- Increase in charity and indigent care

Stabilization Accelerators

- Modern information technology
- Transparency on financial, quality, and outcomes reporting
- Leveraging shared services across operator's system
- Physician enterprise alignment with facility mission and objectives
- Aligned incentives

3.5

CLIN 5 – IDENTIFYING FINANCING OPPORTUNITIES

CLIN 5 UPDATE
TARGETED FINANCING OPTIONS

	FHA Insured		Commercial Bank Financing	Public Private Partnership
	Tax-Exempt Municipal Bonds	GNMA Mortgage Backed Securities		
Tax-Exempt	Yes	No	No	No
Typical Rate Option	Fixed	Fixed	Fixed or Variable	Availability payments are fixed but vary on the P3 structure Terms range from 20-30 years
Rate Ranges	3.00% - 5.00% (a)	4.70% (incl. insurance premium)	LIBOR plus 2.75% - 3.5% (b)	
Term Ranges	25 Years	25 Years	10 - 25 Years	
Est. Max Amortization	25 Years	25 Years	25 Years	
First Mortgage Required	Yes	Yes	Yes	No
Non-Recourse	Yes	Yes	No	No
Debt Service Reserve Fund	Yes	No	No	No
Prepayment Penalties	Yes	Yes	Yes	N/A
Underlying Rating	Yes	No	No	No
Ongoing Financial Covenants	Yes	Yes	Yes	No
Standard Structuring & Closing Timeline	6 - 9 months	4 - 5 months	2 - 4 months	Determined by OP3

(a)For senior-secured S&P rated District of Columbia security instruments issued in the last twelve months. Subordinated or non-rated debt rates are between 5.75% to 10%. The coupon interest rates for bonds with a third-party guarantee will be lower than for bonds without such a guarantee for certain credit qualities.

(b) Applies to entities that have minimum EBITDA of $10MM. In the case of NFPHC, a risk premium should be expected.

CLIN 5 UPDATE
FHA 242 INSURED FINANCING

- Funding options under FHA 242 can be through (1) taxable bonds, (2) tax-exempt bonds, (3) Government National Mortgage Association ("GNMA") securities; or (4) whole loan placements
- The ability to issue tax-tempt bonds will depend on the status of the operating partner and ownership of the new facility
  - A bond will be disqualified for tax exemption if (a) more than 5% of the proceeds are put directly or indirectly to private business use and (b) payment of more than 5% of the bonds is directly or indirectly secured by or to be derived from private business use
    - Leases of bond financed property to entities which are not 501(c)(3) organizations or state or local government units is viewed to be private business use
    - Similarly, management or other service contracts may constitute private use by the service provider if the services provided involve use of the tax-exempt bond-financed facilities
- GNMA mortgage backed securities may be a viable alternative to a tax-exempt bond offering
  - Based on a discussions with a potential FHA 242 lender, current rates for a 25-year (plus construction period) loan are approximately 4.00%. Including a 0.70% mortgage insurance premium, the combined effective rate would be 4.70% which will be fixed for the term of the loan
  - GNMA securities have certain advantages over tax-exempt bonds such as:
    - No rating agency involvement;
    - No restrictions on use of loan proceeds for equipment and IT;
    - No ongoing disclosure requirements;
    - No requirement to fund a debt service reserve fund with debt proceeds

SOURCE: Fundamentals of Tax-Exempt Financing for 501(c)(3) Organizations

CLIN 5 UPDATE
FHA 242 INSURED FINANCING

+ Once details around the new hospital's operating and legal structure has been agreed upon in principle, a pre-application meeting with HUD should be scheduled to discuss the following:
  - Ability of the new hospital entity to obtain a regulatory waiver to allow the District to lease the property to a third-party operator. An alternative would be to have the new hospital entity hold the hospital license and, in turn, enter into an operating or management agreement with a third party
  - The District's commitment to the new hospital
    - Highlight the need for a new hospital and the critical service it would provide the residents of the District and Wards 7 and 8, and demonstrate that the project is consistent with the mission of the FHA 242 program
    - Demonstrate how the District believes the new hospital and operating structure will be different from that of United Medical Center

CLIN 5 UPDATE
PUBLIC PRIVATE PARTNERSHIP (P3)

- The Public-Private Partnership Act of 2014 ("P3 Act") was established by the District to develop innovative solutions to help close the District's infrastructure gap
- The P3 Act defines Public-Private Partnership as the method in the District for delivering a qualified project using a long-term, performance-based contractual agreement between a public entity and a private entity or entities where appropriate risks and benefits can be allocated in a cost-effective manner between the public and private entities in which:
  - A private entity performs functions normally undertaken by the government, but the public entity remains ultimately accountable for the qualified project and its public function; and
  - The District may retain ownership or control in the project asset and the private entity may be given additional decision-making rights in determining how the asset is financed, developed, constructed, operated, and maintained over its life cycle
- Various structures may be contemplated in a P3 depending on the demands and preferences of the District and potential operating partner:
  - The private P3 partner may be involved in all or a mix of the various phases of the project from design, build, finance, operations and maintenance
  - The District's responsibility would be to determine output requirements for the P3 partner to meet and commit to scheduled installment and availability payments upon the P3 partner's satisfactory performance of these requirements

CLIN 5 UPDATE
PUBLIC PRIVATE PARTNERSHIP (P3)

+ Discussions with the Director of the District's OP3, suggest a P3 model to deliver healthcare similar to that in Canada may be viable for the new hospital
  - In traditional government procurement for new infrastructure, the most common method is a design-bid-build structure
    - Under this structure, the public entity is responsible for preparing detailed asset design specifications which it then tenders to a contractor
    - The public entity is ultimately responsible for any design flaws, cost overruns, and has little control over the scheduled completion date
    - The ongoing performance and upkeep of the asset continues to be the responsibility of the public entity
  - Under a P3 structure, a private partner could be engaged under a Design-Finance-Build-Maintain agreement. This would transfer the risk, including cost overruns and schedule delays, to the party best able to manage them – in this instance, the private partner
    - The private partner typically bids a fixed price for the bundled contract, and must pay out of pocket should any unforeseen expenses or delays arise
    - Long-term life-cycle efficiencies are incentivized as the private partner's ability to receive availability payments depends on the underlying asset's ability to perform at an acceptable level
+ A thorough cost benefit analysis needs to be conducted to determine if the benefits derived from the transfer of risk to a private partner outweigh the additional higher project preparation and procurement costs often associated with P3s
+ While the availability payments are dependent on continued provision of services by the private partner, the full cost of the P3 contract will likely be treated as debt and go against the District's debt cap

3.6

CLIN 6 – ASSESSING VIABLE PARTNERSHIPS

POTENTIAL PARTNERS
PARTNERSHIP RATIONALE AND AFFILIATION CRITERIA

The District's long-term goals are to (a) ensure the provision of high-quality healthcare services to all District residents with a focus on serving the residents of Wards 7 and 8, (b) relieve the District of operating responsibility for a hospital, and (c) eliminate or significantly reduce the District's financial obligations for a hospital. The following are the District's criteria in any partnership discussions:

- The new facility will be a full service acute care hospital on the St. Elizabeth campus.
- The anticipated number of beds will be within a range of 100 to 150, although the final bed size is subject to negotiation between the District and selected partner.
- The facility must offer a comprehensive continuum of care, but the District will not require high acuity (quaternary) capabilities or all outpatient services as long as there are care coordination policies in place to address these needs.
- The partner will assume operational control for the facility; the District will expect certain safeguards to ensure quality standards and the continued provision of services, but otherwise the partner will be free to operate the facility as it sees fit.
- The partner will assume financial responsibility for the business, although the District is willing to consider support over a reasonable start-up period.
- The District will commit substantial resources to the development of the facility but expects the partner to contribute as well; such contribution can be in various forms (direct contribution for construction of facility, acquisition of operations, funding ambulatory investments, lease payments, etc.); the selected partner will participate in decisions on financing and structure.
- The District prefers to retain ownership of the real estate to ensure performance on commitments, but is open to alternatives.
- The District is willing to consider additional operators for certain service lines such as skilled nursing and pediatrics; the selected partner will participate in consideration of these options.

POTENTIAL PARTNERS
PREFERRED PARTNER CHARACTERISTICS

The following are key evaluation criteria that will be considered in identifying and ultimately selecting a partner:

- Strong brand and favorable reputation.
- In-market operator offering a continuum of care throughout the District.
- Financial strength.
- High quality of care.
- Modern IT platform.
- Established recruitment platform and experience developing ambulatory programs.
- Experience with community or safety net hospitals.
- Strong management team.

POTENTIAL PARTNER

QUESTIONS FOR POTENTIAL PARTNERS

Huron held discussions with all Tier 1 and Tier 2 potential partners identified earlier. During these meetings we discussed the questions prepared by the District for all potential partners, which as follows:

- Are you interested in participating in the development and operation of a new hospital and health delivery system in Wards 7 and 8?
- What type of new hospital facility do you believe should be established to serve and improve health outcomes for District residents?
- Describe the form of partnership that you envision.
  - What conditions, if any, do you have for operating subsidies by the District for some period post-construction?
  - What conditions, if any, do you have for sharing operating revenues with the District for some period post-construction based on the profitability of the hospital operations?
- Will you contribute capital to the construction of the facility, on-going maintenance of the facility, and/or development of the ambulatory network? If so, please describe your anticipated commitment levels, as well as any conditions you might have regarding the level of commitment.
- At what point in the process would you prefer to participate?
  - Strategic development stage (participate in the site selection, scale of hospital, service offerings) or post-construction phase?
  - Do you have experience in the designing, constructing, financing, operations and management and procurement of such a facility?
- What is your preferred level of engagement with the new hospital facility: owner, lessee, party to long-term third-party agreement (P3), financial contributor to a P3 facility, or none?
- Will you provide a long-term commitment to operate the facility as a general acute care hospital (i.e., a long-term contract with the District for care)?
- What attributes do you bring to the partnership that makes your organization the right partner for the District?
- Does your vision for a new hospital involve an academic training component? If so, please explain your vision for this partnership?


HURON
THANK YOU