VII. STANDING COMMITTEES

A. Academic and Student Affairs Committee

in Joint Session with

B. Finance, Audit and Facilities Committee

Healthcare Review

INFORMATION:

Universities across the country are examining their exposure to the healthcare sector and exploring strategic alternatives that will ensure the success of their affiliated healthcare enterprises. The overarching theme in today's healthcare environment is consolidation driven by healthcare reform.

- Academic Medical Centers ("AMCs") are exploring various expansion models to drive volume to their tertiary/quaternary facilities, improve scale and facilitate clinical integration
- Despite their size, large regional and multi-state health systems are actively seeking growth opportunities to enhance scale and build accountable care organizations
- Community hospitals are debating the merits of remaining independent versus merging with a larger organization, particularly as access to the capital markets has become constrained for weaker credits
- The form of strategic partnership varies significantly and typically is driven by the specifics of the local market

For the University of Washington, UW Medicine is a very substantial financial component that has been growing rapidly. UW Medical Center has experienced tremendous growth over the past decade. The acquisition of Northwest Hospital and the potential for further growth in the future may significantly alter the University's sources of revenue, especially if other revenue streams grow more slowly.

Today's discussion will focus on key trends in the healthcare services market and the changing AMC environment, and examine strategic objectives for UW leadership to consider when evaluating the future of UW Medicine. The discussion will be led by Susan Benz, who heads up healthcare practice at Goldman Sachs and Chris Cowan, head of the higher education group at Goldman Sachs.

This report is for information only.

Attachment
Healthcare Sector Overview

Goldman Sachs

Presentation to the Board of Regents

April 14, 2011

Goldman Sachs

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Executive Summary

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- The overarching theme in today's healthcare environment is consolidation driven by healthcare reform
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I. Healthcare Sector Overview and Trends

Healthcare Services is a large and fragmented market

Spending in the US is forecasted to increase to $4.5 trillion per year by 2019 (6% CAGR)

Acute

- Acute Care Hospitals - $759.1bn
- Physician / Clinical Services - $505.9bn

Post-Acute

- Skilled Nursing / CCRC - $137.0bn
- Home, Health, Hospice
- LTACs
- Rehabilitation
- Renal Care

} $257.7bn

Distribution / PBM

- Distribution
- Institutional Pharmacy
- PBMs

} $249.9bn

Managed Care

- Medicaid / Medicare
- National
- Other
- Regional

} $163.0bn

Outsourcing

- HCIT
- Clinical Labs
- Staffing / Department Outsourcing
- CROs
- Imaging

Source: Centers for Medicare and Medicaid Services

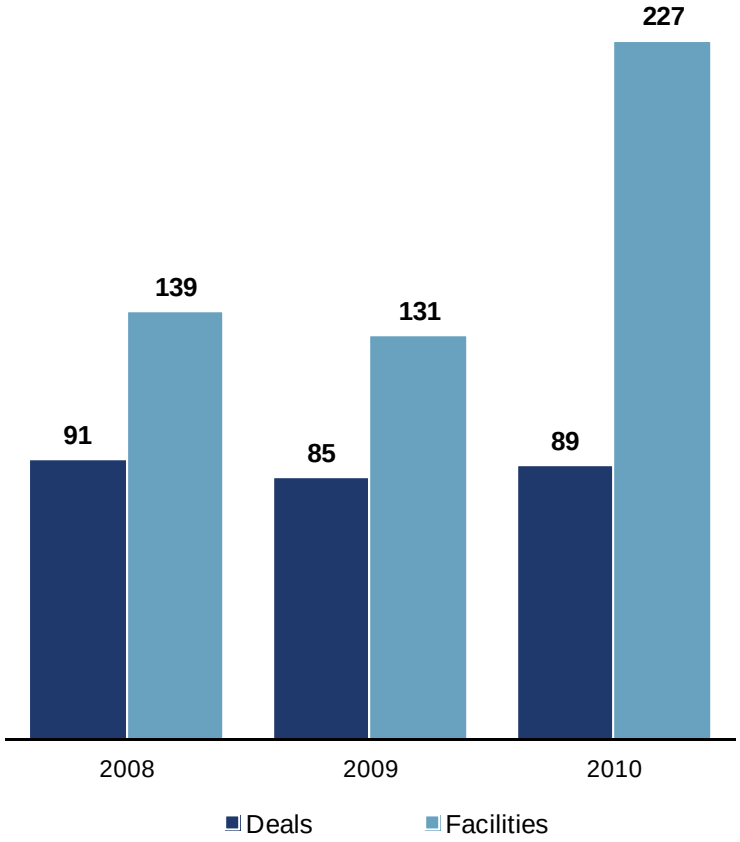
Hospitals have been affected by recent industry trends…

	Key Trends
Volume	■ Hospitals have experienced one of the most difficult patient volume periods in recent history — Through 2010, 70% of hospitals have reported lower overall patient volume and 72% reported depressed volumes of elective procedures — Outpatient trends have generally improved YoY, but revenue per encounter has decreased as a result — The softness in volume appeared to extend to the uninsured admissions, resulting in lower bad debt expense as a % of revenues — Favorable commercial pricing trends have offset softness in volume and are expected to remain strong ■ Unemployment rate remains high at 8.8%; COBRA coverage is lapsing for many unemployed workers ■ Economic conditions are believed to be the main factor in depressed healthcare utilization trends experienced in the second half of 2010
Cost Controls	■ It is unclear if recent cost saving initiatives are sustainable — Most hospitals cut administrative costs, reduced staff and curtailed services — 89% of hospitals indicated no add back of staff or increased staff hours; 98% have not restored previously cut services or programs ■ 67% of hospitals continue to delay or postpone capital projects
Hospital Portfolio Optimization	■ Systems are focusing on how to best optimize their current portfolio of hospitals through either: — Divesting non-core and / or underperforming facilities / businesses — Strategically looking to acquire to facilitate growth
Investment in Technology	■ The impact of the 2009 stimulus bill (ARRA) on provider information technology spend has been significant — Funds available to providers who can demonstrate “meaningful use” of HCIT

Source: Industry Reports and Research

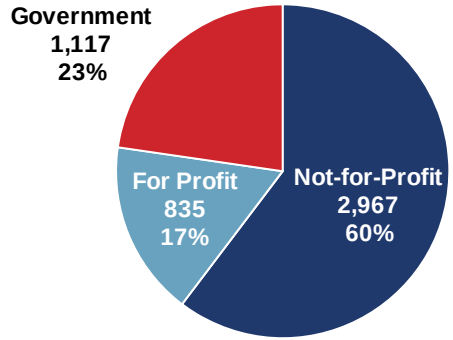
…resulting in more merger activity and an increase of for profit hospitals

Recent Hospital M&A Volume

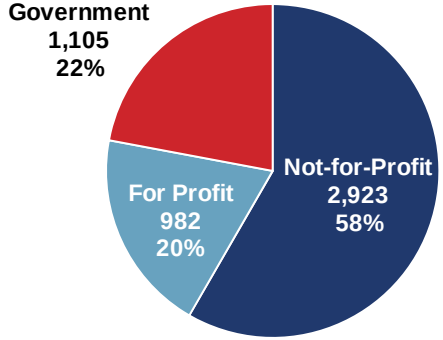


Ownership of US Community Hospitals

2004
Total Hospitals: 4,919 (2,668 in systems)



2009
Total Hospitals: 5,008 (2,868 in systems)



Source: American Hospital Association and Modern Healthcare data

Healthcare reform has helped lay the foundation for continued provider consolidation

Factors Driving Consolidation	Rationale
Reimbursement Pressure	■ Medicare cuts phased in from 2012-2019 for both inpatient and outpatient services — Hospitals are expected to give up $155bn in Medicare funds over the next decade ■ Declining levels of commercial payer reimbursement expected — Commercial payors face increasing pressure to contain costs and manage medical cost trend — Consolidation of health plans creates increased leverage — Higher out-of-pocket costs result in individuals postponing medical care ■ Medicaid revenue also will be pressured as States struggle to balance budgets and respond to the expiration of enhanced FMAP on June 30, 2011
Increasing Insurance Coverage	■ The individual mandate will increase coverage and will reduce the amount of uncompensated care born by hospitals — More than 32mn people are expected to enter the health insurance market ■ Potential for significant increase in healthcare consumption — 20-25% increase in utilization projected for newly insured[1] ■ Larger organizations should be better positioned to capture increased demand and exert incremental operating leverage
Establishment of Accountable Care Organizations	■ ACOs will allow organizations to move from treatment based payment (Fee for Service) to episode based payment (Bundled Payments) to payment for managing populations (Capitation) ■ It is expected that bundled payments will favor larger organizations ■ ACOs are being rewarded for clinical integration ■ ACOs likely need shared governance and sophisticated quality reporting systems

[1] *CBO estimate* *http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf*

A number of factors will drive future success in the Healthcare Sector

Scale	Patient Access	Clinical Integration	Physician Alignment	Expertise	Quality
• Economies of scale reduce costs • Large, integrated organizations have greater negotiating leverage	• Increases customer service capability as insurance coverage expands • Drives referrals, particularly to tertiary/quaternary flagships • Lower cost delivery sites facilitate "right care in the right place at the right time"	• Collaboration among different healthcare providers and sites to ensure higher quality, better coordinated and more efficient services for patients • Serves as a foundation for the management of a specific population (ACO)	• Helps to drive quality initiatives and more cost effective care • Facilitates recruitment and retention • Enhances negotiating leverage	• Evidence-based medicine improves quality • IT and data management are critical to developing best practices and demonstrating superior outcomes • Managing risk - based payments requires specific expertise	• A focus of CMS, success in this area will be rewarded with additional reimbursement • Increased transparency of outcomes is expected to influence consumers' choice of providers

Strategic activity in the not-for-profit healthcare sector has assumed a variety of forms

Form	Recent Examples
Not-for-Profit Acquisition of Not-for-Profit	Indiana University Health / Bloomington Hospital; Trinity Health / Loyola Medicine; Johns Hopkins / Sibley Memorial Hospital; University of Maryland Medical System / Upper Chesapeake Health; Northwestern Memorial Hospital / Lake Forest Hospital; PeaceHealth / Southwest Washington Medical Center
For Profit Acquisition of Not-for-Profit	Vanguard / DMC; HCA / Mercy Hospital
For Profit Partnership with Not-for-Profit	LifePoint Hospitals / Duke University Health System; Baylor Health Care System / Select Medical Corporation; Shands HealthCare / Health Management Associates
Strategic Investments by Managed Care Organizations	Kaiser Permanente / Exempla; Highmark / West Penn Allegheny Health System
Private Equity Acquisition of Not-for-Profit	Cerberus Capital Management, L.P. / Caritas
Not-for-Profit Acquisition of For-Profit	Emory Healthcare / HCA Hospital Corporation of America; USC / Tenet

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II. The Changing Academic Medical Center Environment

AMCs face unique financial challenges relative to their Community Hospital and Health System peers

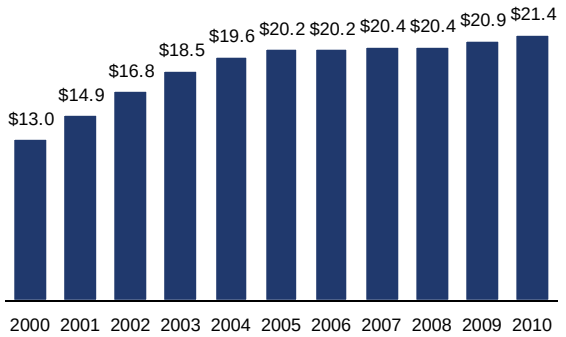
Trend	Notes
AMCs Maintain Higher Medicaid Exposure	■ On average, approximately 3%-5% more of an AMC's revenue come from Medicaid relative to community hospitals[1] ■ AMCs tend to be more concentrated in urban settings, and often draw higher portions of uninsured populations — While caring for this population is consistent with their mission, it puts considerable pressure on financial performance
AMCs Maintain Elevated Levels of Capital Spending	■ AMCs have maintained higher levels of capital spending, with a Capital Spending Ratio on average 0.5x higher[1] than their community hospital peers[2]. This is driven by a number of factors, including: — Modernization of facilities in order to continue to attract physicians and researchers — Tertiary and quaternary programs that require more advanced technologies — Purchase and implementation of IT and medical record technologies

[1] *Source – Moody's FY2009 MFRA financial data.*
[2] *AMCs Capital Spending Ratio is 1.63x as compared to community hospitals of 1.13x*

AMCs face unique financial challenges relative to their Community Hospital and Health System peers (cont'd)

Trend	Notes
AMCs have a Relatively Higher Operating Expense Base	■ GME and research funding typically do not cover the full cost of these activities, and many require cross-subsidization from the clinical mission ■ Employed physicians and/or faculty practice groups typically produce higher wage and benefit expenses ■ The average cost of care per patient is typically higher in an AMC relative to a community hospital ■ Level I trauma centers and burn units require extensive and highly specialized resources available 24/7
AMCs Face Increasing Physician / Faculty Practice Plan Demands	■ Physicians continue to seek supplemental payments for providing services that were once considered routine[2] — 50% of all hospitals report paying physicians for ED call coverage, particularly in surgery, orthopedic and OB/GYN practices ■ Demand for institutional research support is increasing due to limited growth in external funding — NIH funding has been flat over the past 5 years ■ Reimbursement allocations are shifting from specialty to primary care physicians, thereby affecting the economics of faculty practice plans

NIH Grant Dollars ($bn)[1]



[1] *National Institutes of Health..*
[2] *American Hospital Association, The State of America's Hospitals – Taking the Pulse.*

AMCs are pursuing a number of strategies to address possible challenges and create future opportunities

	Strategy	Degree of Implementation
1	Maintain Clinical Strategy	
2	Continue Support of Teaching and Research Missions	
3	Maintain Financial Performance / Current Credit Ratings	
4	Implement Non-Labor Cost Reduction Initiatives	
5	Develop Physician Network and Resource Strategy	
6	Enhance Managed Care Contracting Strategies	
7	Focus on Quality-Based Delivery	
8	Develop and Implement IT Platform	
9	Increase Geographic Reach	
10	Realign Inpatient and Outpatient Portfolio – “Right care in right place at right time”	
11	Enhance Transparency of Financial, Quality, and Productivity Metrics	
12	Increase scale through strategic partnerships with both NFP and FP organizations	

Note : Shaded circle represents a higher degree of existing implementation among Academic Medical Centers.

Recent strategic developments among AMCs

Hospital / Health System	Recent Developments
Johns Hopkins Medicine	■ In April 2011, All Children's Hospital in St. Petersburg joined JHM. JHHS plans to leverage the intellectual and human capital within its pediatrics programs to expand the reach and impact of its current clinical, teaching and research programs ■ On November 1, 2010, Sibley Memorial Hospital officially became part of JHM to address growing interest in more efficient, integrated regional health care services for patients ■ In July 2009, Johns Hopkins Medicine ("JHM") acquired Suburban Hospital Healthcare ("SHHS") building on its longstanding ties with SHHS and expanding its regional presence. SHHS officially joined the Johns Hopkins Health System Obligated Group in July 2010, as part of the Series 2010 bond financing
UCLA Health System	■ On Feb 23, 2011, The Motion Picture & Television Fund (MPTF) entered into a non-binding letter of intent to partner with Providence Health & Services California, contributing the MPTF's Wasserman Campus in Woodland Hills. In conjunction, UCLA Health System will locate a new neurological rehabilitation unit on the Wasserman campus. ■ In June, 2010, UCLA partnered with St. John's Health Center to contribute academic experts to the staff of St. John's existing heart program to better provide care to the hospitals' common service area of Santa Monica and West Los Angeles ■ During 2009, UCLA entered a strategic alliance with Orthopaedic Hospital/Los Angeles, resulting in the relocation of Orthopaedic Hospital's inpatient services to Santa Monica
Duke University Health System	■ On Jan 31, 2010, Duke University's Health System entered into a joint venture with LifePoint Hospitals ■ LifePoint operates 52 hospital campuses in 17 states and specializes in operating community hospitals ■ Duke/LifePoint is one of the first joint ventures between an academic health system and a hospital operating company
USC	■ On Feb 11, 2009, USC agreed to acquire USC University Hospital and USC Kenneth Norris Jr. Cancer Hospital from Tenet Healthcare Corp. for $275mn, ending a three-year dispute over control ■ The two hospitals, on USC's health sciences campus in Los Angeles, have 471 inpatient beds
Ohio State Medical Center	■ OSU is expanding its Medical Center by constructing new towers costing nearly $1bn ■ Construction of new towers started in June 2010 and is expected to be completed by 2014 ■ It includes two towers; 276-bed Ohio State University Comprehensive Cancer Center (OSUCCC) – James and 144-bed Critical Care Center
Emory Healthcare	■ On July 12, 2010, Emory Healthcare and HCA said that they will end a joint venture that began in 1998 ■ Emory will buy out HCA's interest in 72-bed Emory Johns Creek (GA) Hospital ■ HCA will buy out Emory's interest in 247-bed Emory Eastside Medical Center, Snellville, GA

Source: Most recent news runs, official statements (Appendix A), rating reports, and financial statements.

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Appendix A: Academic Healthcare Enterprise Models

Universities utilize a variety of models to integrate their healthcare enterprises

- Healthcare enterprise integration models vary considerably among universities
  - — Full integration: an integrated structure where the School of Medicine ("SOM"), Hospital and Faculty Practice Plan ("FPP") are integrated with the University
  - — Partial integration: some components of the health enterprise (i.e., the Hospital or the FPP) are outside of the University
  - — Non-integrated: all components of the healthcare enterprise (SOM, Hospital and FPP) are outside of the University structure

	Component Integrated with the University		
University	**School of Medicine**	**Hospital**	**Faculty Practice Plan**
University of Washington	✓	✓	✓
Columbia University	✓		✓
Emory University	✓	✓	✓
Harvard University	✓		
Oregon University System			
Stanford University	✓		
The Johns Hopkins University	✓		✓
University of Arizona	✓		
University of California	✓	✓	✓
University of Colorado	✓		✓
University of Connecticut	✓		
University of Massachusetts	✓		
University of North Carolina, Chapel Hill	✓		✓
University of Southern California	✓	✓	✓
University of Utah	✓	✓	✓
University of Virginia	✓	✓	
Vanderbilt University	✓	✓	✓

AMCs have very different relationships with their faculty

- Faculty practice / hospital / university structures vary considerably
  - — Some are fully integrated such as the Mayo Clinic and some have separate yet defined economic and governance arrangements such as New York-Presbyterian

	Affiliation Arrangement with Hospital	Moderate Integration with Hospital	Full Integration with Hospital and University	Physicians and Hospital are a Single Economic Unit (Clinic)
Key Characteristics	■ Hospital purchases / sells services with FPP ■ FPP is either a separate institution or is within the University	■ FPP and Hospital reside within same consolidated entity	■ An integrated structure where Hospital and FPP are integrated with University	■ Hospital employs physicians
Representative Academic Medical Centers	■ Barnes-Jewish Hospital ■ Duke University Health System ■ Johns Hopkins Medical Center ■ New York-Presbyterian ■ Stanford Hospital & Clinics ■ University of Chicago Hospitals and Health System ■ Yale-New Haven Hospital ■ University of California Medical Centers	■ Brigham and Women's ■ Massachusetts General Hospital ■ University of Pittsburgh Medical Center	■ University of Pennsylvania Health System ■ University of Michigan Hospital and Health Centers ■ Vanderbilt University Medical Center ■ University of Washington Medical Center ■ Oregon Health and Science University[1]	■ Cleveland Clinic Health System ■ Mayo Clinic ■ Carilion Clinic ■ Carle Foundation

[1] *Full integration with the school of medicine. Does not imply integration with the Oregon University System.*

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Appendix B: Selected Case Studies

AMC / University Case Studies

Corporation Information

Headquarters:	Baltimore, MD
Local Hospital Beds:	1593
Total Local Facilities:	5[1]
Employed Physicians:	N/A
Number of Physician Staff:	4,494[2]
Academic Affiliation:	Johns Hopkins University
Ratings (Moody/S&P/Fitch):	Aa3[3] / A+ / AA-
Managed Care:	None

Key Financial Metrics (FYE 06/30)

	2009	2010
Operating Revenue ($mn)	$3,296.9	$3,725.5
Operating EBIDA ($mn)	259.5	333.9
Operating Margin (%)	3.1	2.4
Operating Cash Flow Margin (%)	7.9	7.5
Unrestricted Cash ($mn)	1,258.0	1,284.6
Total Debt ($mn)	1,501.7	1,142.4
Unrestricted Net Assets ($mn)	748.2	942.8
Days Cash on Hand	148.9	155.3
Debt/Capitalization (%)	58.0	56.8

Strategic Action and Rationale

- Johns Hopkins Medicine ("JHM") has been growing through acquisitions
  - In the Maryland / D.C. area, JHM recently bought Suburban Hospital ("Suburban") and Sibley Memorial Hospital ("Sibley")
  - In Florida, JHM acquired All Children's Hospital & Health System
- Acquisition of All Children's enables JHM to expand its mission-centric work in pediatric health care research, teaching and clinical delivery
- Acquisition of Suburban and Sibley expands JHM's market presence in the region, enhances its referral network and enables it to expand its continuum of care and clinical research opportunities
  - Suburban and JHM have had an alliance dating back to 1996. In 2006, the two institutions collaborated with the NIH to form the NIH Heart Center at Suburban Hospital offering advanced cardiovascular specialty care, including cardiac surgery

[1] Does not include All Children's Hospital, Florida.
[2] Does not include active medical staff at Suburban and Sibley Hospitals.
[3] In 2010, Moody's upgraded Johns Hopkins from A1 to Aa3.

AMC / Hospital Management Company

Corporation Information

Headquarters:	Durham, NC
Local Hospital Beds:	1,498
Total Local Facilities:	3
Employed Physicians:	137[2]
Number of Physician Staff:	1,879
Academic Affiliation:	Duke University
Ratings (Moody/S&P/Fitch):	Aa2/AA/AA
Managed Care:	None

Key Financial Metrics (FYE 12/31)

	2009	Q3 2010 Annualized
Operating Revenue ($mn)	$2,015.8	$2,149.6
Operating EBIDA ($mn)	302.9	377.7
Operating Margin (%)	6.0	7.7
Operating Cash Flow Margin (%)	11.5	13.5
Unrestricted Cash ($mn)	1,174.6	1,475.9
Total Debt ($mn)	688.3	972.9
Unrestricted Net Assets ($mn)	1,348.0	1,516.9
Days Cash on Hand	236.6	284.5
Debt/Capitalization (%)	33.8	39.1

Strategic Action and Rationale[1]

- Duke University Health System ("DUHS") has limited growth opportunities in its primary market with the three largest health systems controlling over 90% of the market share[3]
- Seeking to grow outside its primary market, it partnered with LifePoint Hospitals, a for-profit hospital management company to form the Duke / LifePoint Network
  - Affiliation is one of the first joint ventures between an AMC and a for-profit hospital operations company
- Maria Parham Medical Center, a private, non-profit community hospital is the first facility to join the Duke / LifePoint Network
- LifePoint will bring a range of financial and operational resources including access to capital to the joint venture. DUHS will provide guidance in clinical service development and support for enhancing quality systems as well as access to highly specialized medical services
- Joint Venture enables DUHS to grow outside its immediate market and share risk with a highly experienced community hospital operator

[1] *Source: February 1, 2011 LifePoint Hospital and Duke Medicine Case Study.*
[2] *Duke University Affiliated Physicians.*
[3] *HealthLeaders, February 2010.*

AMC / University Case Studies

Corporation Information

Headquarters:	Columbus, OH
Local Hospital Beds:	1,326
Total Local Facilities:	4 hospitals
Employed Physicians:	617
Academic Affiliation:	The Ohio State University
Ratings (Moody/S&P/Fitch):	Aa1/AA/AA
Managed Care:	None

Key Financial Metrics (FYE 06/30)[1]

	2008	2009
Operating Revenue ($mn)	$1,460.0	$1,578 .0
Operating EBIDA ($mn)	165.0	170.7
Operating Margin (%)	-	-
Operating Cash Flow Margin (%)	11.3	10.8
Unrestricted Cash ($mn)	-	-
Total Debt ($mn)	-	-
Unrestricted Net Assets ($mn)	-	-
Days Cash on Hand	-	-
Debt/Capitalization (%)	-	-

Source: Most recent Appendix A, audited financial statements – OSU does not publish consolidating financials, HealthLeaders-InterStudy and news runs.

[1] *Includes only hospital statistics.*

Strategic Action and Rationale

- In 2010, OSU Physicians, the faculty practice plan composed of 617 doctors, became full-time employees of the University
- Integration with the University and the Hospital enables further leveraging of scale
  - OSU Medical Center and OSU Physicians can now negotiate reimbursement contracts as a single entity further strengthening its dominant position as the only AMC in the market
  - Of particular importance to OSU physicians was the ability to negotiate better malpractice insurance rates
- Closer integration of OSU Medical Center and OSU Physicians will enable the implementation of a complete electronic medical record ("EMR")
  - The implementation of an EMR is a key incentive of the Healthcare Reform Bill
- Closer integration will also enable joint programmatic planning and facilitate more robust cost and quality management initiatives

AMC / University Case Studies

Corporation Information

Headquarters:	Winston-Salem, NC
Local Hospital Beds:	872
Total Local Facilities:	2
Employed Physicians:[1]	650
Number of Physician Staff:[1]	650
Academic Affiliation:	Wake Forest University
Ratings (Moody/S&P/Fitch):	Aa3 / AA- / NR
Managed Care:	None

Key Financial Metrics (FYE 06/30)

	2009	2010
Operating Revenue ($mn)	$992.1	$971.4
Operating EBIDA ($mn)	81.8	102.1
Operating Margin (%)	0.2	2.9
Operating Cash Flow Margin (%)	8.2	10.5
Unrestricted Cash ($mn)	636.9	724.4
Total Debt ($mn)	332.0	338.0
Unrestricted Net Assets ($mn)	708.0	785.4
Days Cash on Hand	252.0	300.5
Debt/Capitalization (%)	31.9	30.1

Strategic Action and Rationale

- Wake Forest Baptist University Medical Center ("WFUBMC") is composed of North Carolina Baptist Hospital ("NCBH") and Wake Forest University Health Sciences ("WFUHS") which includes the Faculty Practice Plan
- Process is underway to integrate WFUHS and NCBH under a single governance model still retaining the WFUBMC name
- Integration benefits include:
  - Allows WFUBMC to have a sustainable growth model to achieve its strategic goals
  - Enhances physician and researcher recruitment and retention efforts
  - Increases market clout with payers by combining Faculty Practice Plan and Hospital
  - Leverages scale to produce cost savings and operating efficiencies
  - Positions the organization more effectively for Healthcare Reform particularly concerning quality initiatives

[1] *Currently part of WFUHS.*

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