Bartlett Regional Hospital

AGENDA
AD HOC PLANNING MEETING
Thursday November 25, 2020 – 12:00 p.m.
Bartlett Regional Hospital Zoom Video Conference

Public may follow the meeting via the following link https://bartletthospital.zoom.us/j/98624799495

or call
1-253-215-8782 and enter webinar ID 986 2479 9495

I. CALL TO ORDER

II. PUBLIC COMMENT

III. NEW BUSINESS

1. Priority "Asks" from a relationship (Pg.2)
   A. Clinical
   B. Managerial / Supportive Services

2. Values we can add to a relationship

3. Update on potential partners
   A. Letter of interest from University of Washington (Pg.37)
   B. Letter of interest from SEARHC (Pg.38)

4. Discussion Document (Pg.39)

IV. COMMENTS

V. NEXT MEETING

VI. ADJOURN

CONFIDENTIAL
DISCUSSION DRAFT
6-23-20

Bartlett Regional Hospital

Provider Network Development Analysis

Final Report

June 23, 2020

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I. Executive Summary

I. Executive Summary

A. Engagement Overview

ECG was engaged to assist Bartlett Regional Hospital (BRH) and the City and Borough of Juneau (CBJ) in developing a comprehensive situational assessment and provide leadership with a detailed analysis of available strategic options. The purpose of this document is to:

» Objectively assess BRH's strategic, market, and financial situation and determine its ability to remain viable into the foreseeable future.

» Evaluate potential strategic initiatives and alternatives the organization can undertake to enhance its future-state vision.

» Assess and evaluate the strategic alternatives related to BRH's future-state goals and objectives.

B. The "Most Responsible Moment"

When an independent organization cannot fully execute its strategic imperatives, an affiliation or partnership may be necessary. ECG believes BRH is at its most responsible moment; meaning, BRH has reached the point where not committing to an affiliation or partnership strategy is a greater cost than that of committing. BRH's historical strategic, market, and financial position indicates they can negotiate from a position of strength, but if the decision to develop a strategic relationship is delayed, the negotiating platform will deteriorate due to several key challenges that the organization will likely face in the next one to three years. The remainder of this document aims to outline the key drivers and assumptions that drive ECG's belief.

C. Key Findings

Our analysis indicates that BRH is currently financially sustainable. However, while ECG believes BRH's status as a going concern remains intact, this belief is tenuous due to the high likelihood of BRH being materially impacted by one or multiple significant regional and industry trends that will challenge its ability to operate independently over the coming years. These factors include the following:

» Historically, BRH's greatest strategic advantage was the remoteness of Juneau and the lack of significant competitor presence in the market. Over the past decade, SouthEast Alaska Regional Healthcare Consortium (SEARHC) has continued to expand its presence in the CBJ and is able to fund continued regional expansion through favorable government and tribal reimbursement that is not available to BRH. SEARHC has demonstrated its desire to grow as a southeast Alaska integrated health system with its acquisitions of Mt. Edgecumbe Medical Center in Sitka and Wrangell Medical Center in Wrangell. More recently and perhaps most concerning to BRH, SEARHC acquired 17 acres of undeveloped land on which to build facilities and expand offerings, which may include specialty care and imaging, presenting a significant threat to BRH's financial viability as

these services represent high-margin activities to BRH and competitive pressure may materially draw volume outside of BRH.

» The impact of COVID-19, coupled with the current market volatility of oil prices, has created a state budget crisis resulting in the possibility of the constitutional budget reserve being empty by FY 2022. Though BRH has significant cash reserves and will likely be able to weather this form of economic downturn, the overall state financial outlook could impact BRH's margin through changes to payer mix, requests to use BRH's cash reserves by local government, and declines in volume as residents may leave the community for employment.

» While BRH has demonstrated above expected liquidity, the current capital plan cannot be solely supported by operating cash flows. Further, CMS's Rural Community Hospital Demonstration (RCHD) is set to expire in June with the net impact effectively reducing BRH's operating EBIDA margin to 2.8%, leading to further dependence on cash reserves. While ECG and BRH leadership believe that the sunsetting of the RCHD at this time is unlikely, the reliance on a federal program outside of BRH's core competencies for financial sustainability does present future risk.

» Declines in the regional tourism industry over the next one to three years will temporarily change the volume at BRH and will likely reduce cash reserves further. Seasonal revenue derived from tourism will decline and lead to higher regional unemployment and an estimated BRH revenue stream reduction of 10% to 15%.

» Pressure on health systems and hospitals to reduce costs has resulted in the ambulatory migration of key services. By 2026, over 50% of orthopedic joint replacement cases are projected to be performed in the outpatient setting, putting over $3 million in BRH orthopedic surgical revenue at risk and ultimately leading to patient leakage.

» As the sole community provider, BRH is especially susceptible to changes in the current competitor footprint. Key specialty gaps exist within BRH that will continue to create natural out-migration into other communities, and SEARHC's increasing market precense exacerbates the risk of patient leakage. Stagnant organic population growth in the CBJ will limit BRH's prospects for improving market capture, and a lack of local health plan incentives for government employees further highlights BRH's challenge of stemming patient leakage. Physician recruitment will continue to be an ongoing issue due to the geographic isolation of Juneau and Alaska's fragmented physician landscape. Only 1% of final-year medical residents have expressed the desire to pursue employment in a rural setting, indicative of ongoing recruitment difficulties into the future.

D. Strategic Options and Recommendation

ECG recommends BRH pursue a clinical service JV or clinical affiliation agreement with a provider that can bring a wider range of specialties and new services to the region while allowing the broader system to remain independent. These models will allow BRH to stabilize and expand access for patients to key service lines and physician specialties while also maintaining autonomy. A clinical service JV and clinical affiliation agreement do not fully insulate BRH from the threat of competitors entering the market, but they will provide BRH with a platform to address the need for specialists in the community and a potential expansion of services that patients currently must travel for.

II. Engagement Overview

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A. Engagement Background

BRH is the sole community provider of hospital services within the CBJ. With primary competitors located at least 400 miles away, BRH is uniquely positioned to provide care across approximately 3,250 miles of the southeastern Alaska Panhandle. The nature of the geography, as well as the distinctive competitive landscape in the state, has allowed the organization to secure a stable market and financial outlook; however, the traditional market boundaries that once made Juneau a largely self-contained healthcare service area may be redefined by efforts to reduce the cost of care through innovative methods of access and evolving care pathways.

While BRH has demonstrated its commitment to providing high-quality care through top-quartile performance in readmissions, HCAHPS, and Medicare's Value-Based Purchasing Program performance scores, the operating cost structure that is required to sustain this performance in Alaska is high. In fact, BRH's current operating expenses per adjusted patient day are among the highest in the country. This degree of investment makes the organization particularly vulnerable to reimbursement changes and the potential out-migration resulting from payers directing patients to out-of-state providers. In fact, BRH's second largest competitor in terms of leakage is Virginia Mason Medical Center in Seattle.

While many health systems in the state have been able to mitigate this impact through a partnership or alternative reimbursement models (e.g., tribal affiliation), as an independent health system, BRH has managed to remain viable through more traditional management. To date, this approach has been successful, as BRH's Board of Directors and management believe that the organization is currently in a strong financial and market position. However, in light of the changing healthcare landscape and factors like those discussed above, the board feels the need to proactively evaluate how to best maintain and expand upon BRH's existing strengths. It also wants to evaluate strategic alternatives in order to better define and identify the most effective options for the organization's long-term success.

B. Engagement Objectives

To achieve these goals, BRH and the CBJ engaged ECG to conduct a comprehensive situational assessment and provide leadership with a detailed analysis of available strategic options. Specifically, BRH and the CBJ requested:

- A thorough situational assessment outlining the most relevant commercial, organizational, and statewide factors that will be pertinent to planning for the future positioning of the organization
- A thoughtful evaluation of BRH's current-state trajectory that is accompanied by available strategic options, including short- and long-term analyses, tradeoffs, and the implications of any changes on the medical staff

C. Methodology

Based on ECG's experience with other community hospitals that were exploring their strategic options, the process that BRH and the CBJ employ can be as important as the outcome; constituents and regulators will ask whether the BRH Board of Directors honored its fiduciary responsibility to objectively evaluate its options. Ultimately, the fundamental determination of whether BRH should consider a strategic partnership of any type should be based on that partner's ability to successfully meet the needs of its community and independently achieve its strategic goals. Accordingly, our method was designed to help BRH objectively make a decision and ensure its board could confidently represent to the community that all potential courses of action were thoroughly examined in the best interest of the organization and the population it serves.

As part of this approach, ECG engaged BRH board members and executive leadership and members of the medical staff to provide guidance and support in evaluating BRH's future direction.

III. Situational Assessment

III. Situational Assessment

In order to evaluate the strategic positioning and outlook of BRH, a thorough analysis begins with understanding the national and regional trends that impact independent community hospitals. These trends provide relevant context that ultimately will help BRH develop their strategy. The healthcare landscape has created unique challenges for healthcare organizations. In responding to a world in which the framework and basis of competition are always changing, a community hospital strategy must consider more than traditional performance measures. Such a strategy must account for external forces and regional trends and be implemented before the full impact manifests at the local level.

A. National Community Hospital Trends

» *Reimbursement Adequacy:* As Medicare grows to be a larger portion of an organization's revenue base, and reimbursement rates remain flat, successful organizations are seeking higher-yielding revenue sources, such as value-based care.[1] Pursuing value-based care is especially difficult for rural hospitals as they grapple with the challenge of operating with high fixed costs and continual reductions in reimbursement. For example, in efforts to reduce the federal budget, Congress passed Medicare sequestration in 2011, which cut all payments to hospitals by 2%—these cuts have been extended several times.[2]

» *Staff and Provider Shortages:* The United States is projected to see a shortage of physicians (nearly 122,000 by 2032) and nurses as demand intensifies due to the growing and aging population.[3] The trend is intensified in rural communities due to challenges in recruitment and succession planning.

» *Recruitment and Succession Planning:* Recruiting challenges specific to community hospitals (geographic isolation, small local candidate pool, etc.) means organizations must have a longer lead time for physician recruitment and an increased focus on succession plan development.

» *Ambulatory Migration of Key Services:* As the Centers for Medicare & Medicaid (CMS) expands cases that can be seen in the outpatient environment and payers drive toward site neutrality, leaders need to evaluate sites of care.[4] "Site-neutral" policies that seek to reduce reimbursement for nonemergency services delivered in hospitals' off-campus, provider-based departments have disproportionately impacted rural providers by reducing reimbursement for primary patient access

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1 "NHE Fact Sheet," CMS, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.

2 "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

3 "New Findings Confirm Predictions on Physician Shortage," AAMC, April 23, 2019, https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage.

4 "Ambulatory Surgical Center Payment System," CMS, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/AmbSurgCtrFeepymtfctsht508-09.pdf.

points. Recent proposals have indicated future reductions to provider-based departments that were previously exempt from reimbursement cuts.[5]

» *Patient Leakage:* Patients leave the community for services that could otherwise be performed at the local community hospital, largely driven by changing demographics and high-acuity episodes of care.[6]

» *Behavioral Health and Substance Use Disorder Treatment Scarcity:* As demand for these kinds of treatments increases, workforce shortages, unsustainable service models, and insufficient funding limit the ability of organizations to meet community demand.[7]

» *Overhead Scale:* Without partnership support, the localized structure of the community hospital limits the ability to realize regional economies of scale through overhead allocation.

B. Regional Community Hospital Trends

» *Hospital Market:* Multistate health systems have consolidated much of the Alaska market, including Providence Health & Services in Anchorage and PeaceHealth in Ketchikan. Providence operates as a system in seven states, with 51 hospitals and over 800 physician clinics, and PeaceHealth has approximately 16,000 caregivers, a medical group practice with more than 1,100 providers, and 10 medical centers that serve both urban and rural communities throughout the Northwest. In addition, SEARHC has been active in expanding its geographic reach with the acquisition of Wrangell Medical Center in 2018[8] and Mt. Edgecumbe Hospital in 2019.[9] SEARHC also purchased 17 acres of undeveloped land in Juneau in 2018[10] and the same year signed a Letter of Intent with Swedish Medical Center in Seattle, which is affiliated with Providence, for the purpose of expanding specialty services and clinics in Southeast Alaska.[11]

» *Physician Landscape:* A fragmented physician landscape and difficulties with physician recruitment will continue to be ongoing challenges faced by Alaska health systems. Recruiting is challenging

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5 "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

6 Definitive Healthcare; annual Medicare data from CMS Medicare Standard Analytical Files (SAFs). The most recent annual Medicare data from calendar year 2018.

7 "National Projections of Supply and Demand for Selected Behavioral Health Practitioners: 2013–2025," https://bhw.hrsa.gov/sites/default/files/bhw/health-workforce-analysis/research/projections/behavioral-health2013-2025.pdf.

8 June Leffler, "After Months of Negotiations, SEARHC Takes over Wrangell Medical Center," Alaska Public Media, November 1, 2018, www.alaskapublic.org/2018/11/01/after-months-of-negotiations-searhc-takes-over-wrangell-medical-center.

9 "Mt. Edgecumbe Medical Center (S'ÁXT' HÍT)," SEARHC, June 7, 2020, https://searhc.org/location/mt-edgecumbe-hospital.

10 "Finance Homepage," City and Borough of Juneau Assessor's Database, https://property.juneau.org/parcel-7B0901100000.

11 "SEARHC Signs Letter of Intent with Swedish to Expand Specialty Services," SEARHC, September 12, 2018, https://searhc.org/searhc-signs-letter-intent-swedish-expand-specialty-services.

due to geographic isolation, personal and professional isolation, and a lack of qualified candidates (physicians are often required to work without direct supervision or colleagues for support).[12]

» *COVID-19:* BRH's workforce, community, and organizational performance are negatively impacted by the effects of COVID-19 on the cruise season, as nearly 500 cruises have been canceled for 2020. Further, the negative impact of COVID-19 on state and local budgets has pushed Alaska dangerously close to a fiscal cliff, which will have a trickle-down effect on BRH and the CBJ due to state support weakening and the PERS obligation becoming a higher-risk liability.

[12] "2016 Alaska Health Care Workforce Profile," https://www.uaa.alaska.edu/academics/college-of-health/departments/acrhhw/dataandreportspages/_documents/2016-AK-Health-Care-Workforce-Profile.pdf.

IV. Financial Position Assessment

IV. Financial Position Assessment

ECG assesses the financial position of an organization according to the methodology used by Moody's and other credit agencies for determining financial sustainability and credit worthiness. The ratings are from before COVID-19 and consider a range of qualitative and quantitative measures, including but not limited to the variables depicted in table 1.

Table 1: Moody's Financial Sustainability and Credit Worthiness Measures[13]

Type	Measure		
Qualitative Measures	» Revenue structure » Revenue-raising ability and tolerance » Political dynamics	» Quality of financial management (budgetary, capital, and strategic planning) » Timely implementation of strategies in response to changing internal and external dynamics » Public policy frameworks	» Track record of social and political stability » Assessment of political commitments (fiscal adjustment, oil price stability) » Environmental issues
Quantitative Measures	» Structure of the economy » Investment rate, saving rate » Inflation record » Demographic trends (e.g., trends of personal income and wealth, tax base growth trends, employment growth, unemployment rate, population growth, age distribution, and geographic concentration)	» Financial operations (e.g., expense structure, including fixed cost trends, trend of budget surplus or deficit, size and liquidity of financial reserves) » Factors that help assess the sustainability of public debt » Off-balance sheet liabilities	» Future liabilities such as pension and healthcare costs » Composition of the debt in terms of maturity, interest-rate sensitivity, and the size of assets that can be liquidated

Compared to similarly sized organizations, BRH performs near the level of a Baa3-rated organization (table 2), which places BRH on the lower end of investment grade performance. While this position is considered sustainable, there are nuances that provide additional levels of concern. Baa3-rated organizations are especially susceptible to adverse economic conditions or changing circumstances; with regards to BRH, the vulnerability created by COVID-19 has materially weakened BRH's capacity to meet its financial commitments.

[13] "Procedures and Methodologies Used to Determine Credit Ratings," Moody's Investors Service.

Table 2: Moody's Rating Scale

Grade	Rating Symbols	Rating Notches	Comments
Investment Grade	Aaa		Highest quality, subject to the lowest level of credit risk
	Aa	Aa1 Aa2 Aa3	High quality, subject to very low credit risk
	A	A1 A2 A3	Upper-medium grade, subject to low credit risk
	Baa	Baa1 Baa2 Baa3	Medium-grade, subject to moderate credit risk and may possess certain speculative characteristics
Speculative Grade	Ba	Ba1 Ba2 Ba3	Judged to be speculative, subject to substantial credit risk
	B	B1 B2 B3	Considered speculative, subject to high credit risk
	Caa	Caa1 Caa2 Caa3	Speculative and likely in, or very near, default, with some prospect of recovery of principal and interest
	Ca		Speculative of poor standing and subject to very high credit risk
	C		Speculative and likely in, or very near, default, with some prospect of recovery of principal and interest

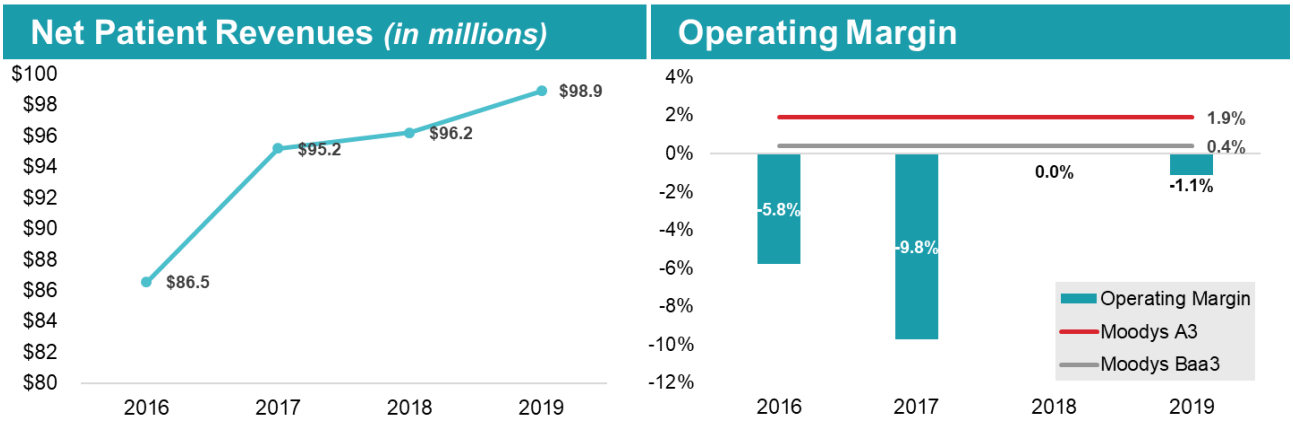
C. BRH Internal Assessment

Organizational financial positioning is best understood by considering how well positioned a system is to answer key strategic questions, ultimately determining credit-worthiness.

Profitability: Net patient service revenue increased 2.8% from FY 2018 to FY 2019; meanwhile, operating margin decreased from 0.0% to -1.1% (figure 1). The current operating margin indicates a credit worthiness equal to an organization rated as Baa3, indicating adequate performance but increased susceptibility when exposed to adverse market conditions. Comparing expenses to similarly sized

organizations in the Alaska market, BRH has historically performed favorably, with an expense per discharge that is 9% lower than that of PeaceHealth Ketchikan Medical Center in FY 2019.[14]

Figure 1: BRH Net Patient Revenue and Operating Margin

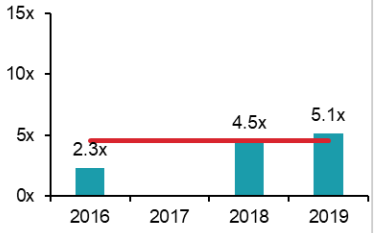
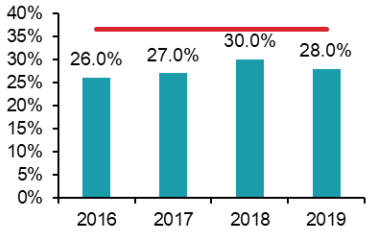
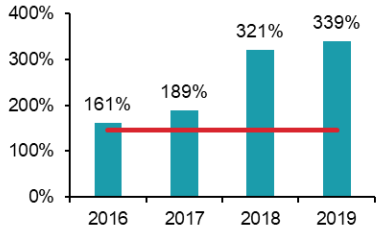


» *Debt Position:* Based on FY 2019, BRH was performing above Moody's A3 median of 4.5x, indicating a strong ability to service its debt (figure 2). Additionally, BRH has the capacity to borrow incremental debt if needed; however, the decreases in state and CBJ general funds may limit borrowing options.[15]

[14] FY 2016 to FY 2019 data from audited financial statements. FY 2020 sourced from internal 1/17/20 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

[15] Ibid.

Figure 2: Debt Capacity Analysis

Item	Approach One: Cash Flow	Approach Two: Debt to Capitalization	Approach Three: Cash to Debt
Historical Position			
Debt Capacity	Moody's A3 Median: 4.5x	Moody's A3 Median: 36.6%	Moody's A3 Median: 145.1%
Commentary	The ability to service debt is the ultimate determinate of capacity.	While debt to capitalization is the least important factor, it is still relevant from a capital structure perspective.	This approach is dependent on relationship of unrestricted cash to long-term debt.

BRH Moody's A3

» *Liquidity:* Historically, BRH has high levels of balance sheet liquidity, but its low EBIDA margin indicates cash flows from operations (figure 3) will not be able to support future capital needs through operations alone. Capital expenditures total $57 million over the next five years, with approximately 82% of that amount planned for department improvements (figure 4). Additionally, BRH has an old infrastructure that will require many repairs and a high level of maintenance going forward.[16]

16 Ibid.

Figure 3: BRH Operating EBIDA Performance

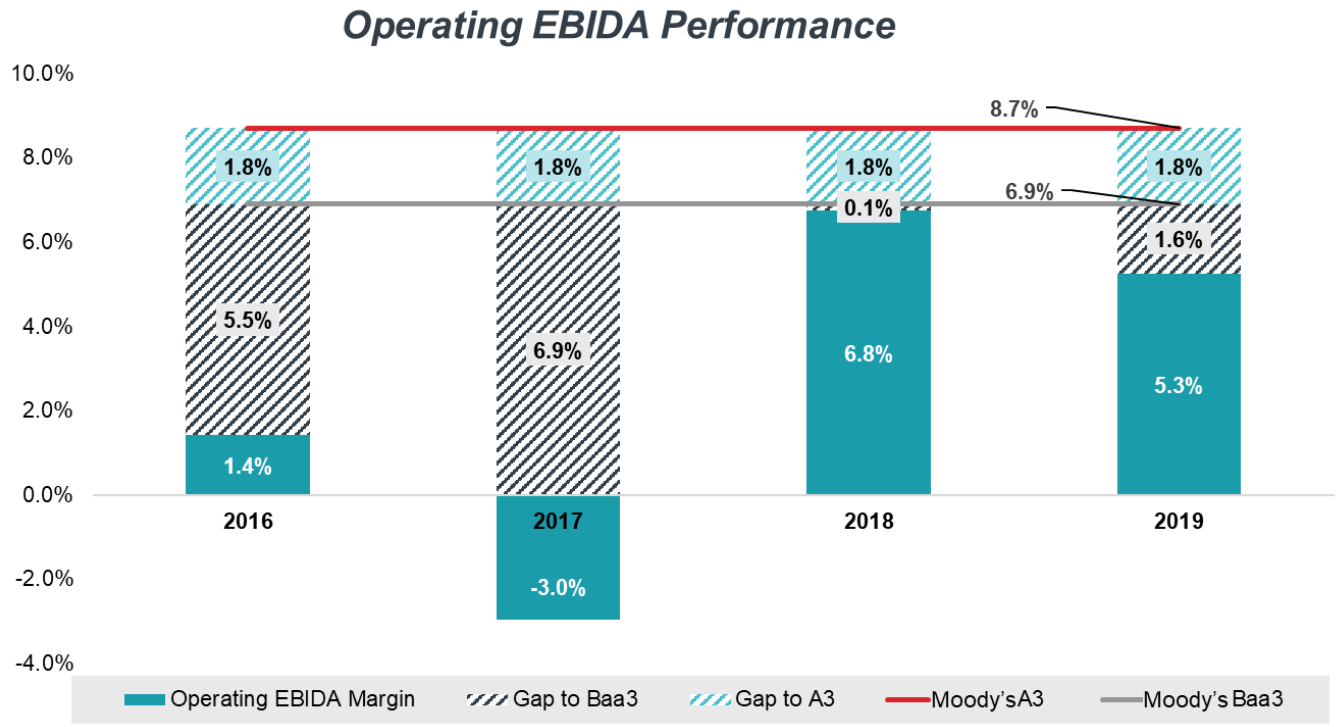
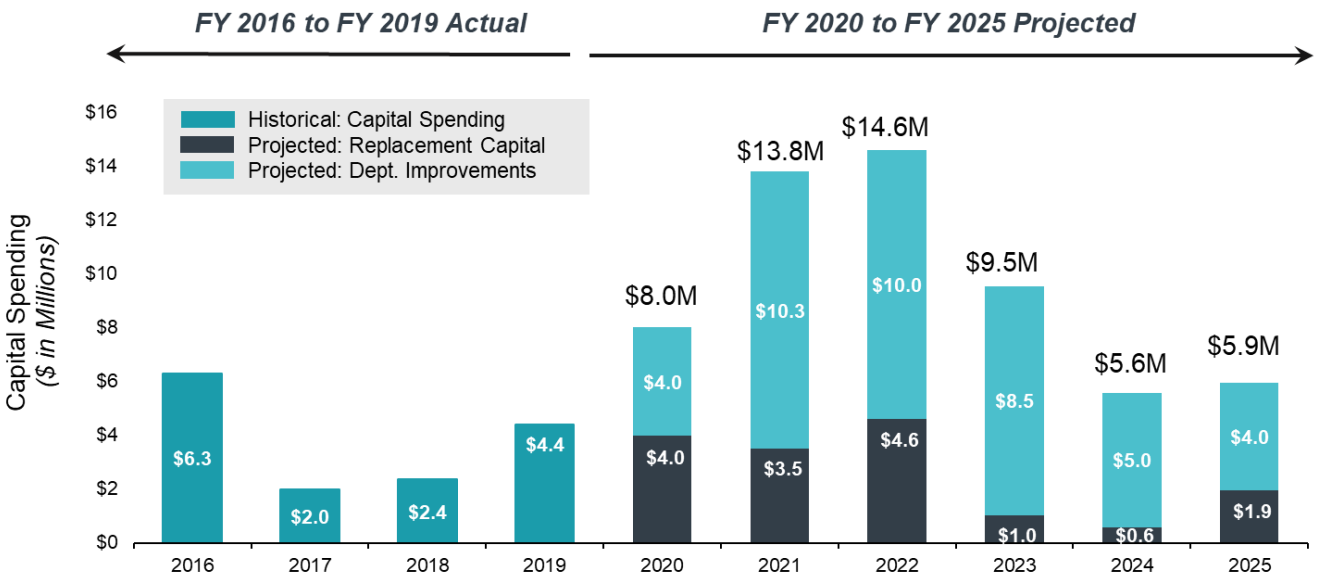


Figure 4: BRH Capital Plan



Notes: FY 2016 – FY 2019 data from audited financial statements. FY 2020 sourced from internal January 17, 2020 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

» *CMS Rural Community Hospital Demonstration:* The goal of this program is to test the feasibility and advisability of cost-based reimbursement for small rural hospitals that are too large to be

designated as Critical Access Hospitals. CMS is conducting an intensive evaluation of the demonstration to assess the financial impact on participating hospitals, as well as the effect on the healthcare of the populations served. For FY 2019, the benefit of this program increased BRH's Medicare reimbursement by $4.8 million, indicating a significant impact on reimbursement if this project is not renewed. BRH comes to the end of its five-year cycle on June 30, meaning there will be a $3.2 million reduction in its Medicare reimbursement, factoring in the $1.5 million in additional reimbursement BRH would receive from applying to CMS for a Low-Volume Hospital Payment Adjustment to its DRG rates.[17] CMS has not released a statement regarding the termination or continuation of the demonstration.

» *Public Employees' Retirement System (PERS) Obligation:* PERS is a cost-sharing, multiple employer–defined benefit pension plan administered by the State of Alaska that provides retirement, health insurance premium supplement, long-term disability, occupational death and disability, and survivor benefits. BRH's net pension liability for FY 2019 was $60.3 million. BRH's obligation decreases operating margin for the organization and may limit available partnership opportunities given the cash required to resolve the balance in an acquisition-style transaction.[18]

» *COVID-19:* COVID-19 first affected operations at BRH in March. Revenues and volumes were strong through the first half of the month, but in response to COVID-19, outpatient services were discontinued, and services were only provided to inpatients and emergency patients. The result was a 50% reduction in daily revenue, 24% reduction in inpatient revenue. and 8% reduction in outpatient revenue.[19]

Table 3 summarizes the analysis of BRH's profitability, debt position, and liquidity.

17 "Budget Packet— FY 2021," Bartlett Regional Hospital, https://www.bartletthospital.org/media/38527/fy21-budget-packet.pdf.

18 FY 2016 to FY 2019 data from audited financial statements. FY 2020 sourced from internal 1/17/20 Finance Committee Packet. FY 2021 to FY 2025 capital plan provided by BRH leadership.

19 "5-26-2020 Board of Directors Packet," Bartlett Regional Hospital, https://www.bartletthospital.org/media/38724/05-26-2020-board-of-directors-packet-public-revised-v2.pdf.

Table 3: Historical Credit Profile

Ratio/Statistic	Fiscal Year-End June 30			
	2016	2017	2018	2019
Total Operating Revenue	$90.6	$98.5	$99.8	$102.5
Net Patient Service Revenue	$86.54	$95.19	$96.20	$98.91
Operating Income	$(5.25)	$(9.60)	$(0.02)	$(1.17)
Operating EBIDA	$1.96	$(2.24)	$7.40	$6.02
Adjusted Net Income	$(4.77)	$(9.41)	$(0.24)	$0.89
Adjusted Net Revenue Available for Debt Service[1]	$3.12	$(1.38)	$7.84	$8.72
Cash Flow (Net Income + D&A)[2]	$3.90	$(0.59)	$7.19	$8.08
Unrestricted Cash[3]	$37.64	$42.26	$68.68	$69.01
Capital Expenditures	$23.38	$22.40	$21.40	$20.39
Profitability				
Operating Margin	(5.8%)	(9.8%)	0.0%	(1.1%)
Operating EBIDA Margin	1.4%	(3.0%)	6.8%	5.3%
Debt Position				
Coverage	2.3x	(0.9x)	4.5x	5.1x
Total Debt to Capitalization	63.6%	68.7%	63.1%	64.2%
Liquidity				
Cash to Total Debt	54.5%	44.6%	86.7%	81.6%
Days Cash on Hand[4]	188	198	262	266
Other				
Capital Spending Ratio	87.3%	26.8%	31.7%	61.1%

Notes: Credit ratings sourced from BRH Moody's Credit Opinion published 08/29/2019. BRH data is based on audited financial statements, continuing bond disclosures, and internal management reports. All dollar amounts are in millions.
[1] FY 2018 adjusted net revenue available for debt service and adjusted DSCR normalized for investment loss.
[2] Includes inflows from local government.
[3] Unrestricted cash defined as cash + cash equivalents + long-term investments.
[4] Days cash on hand defined as unrestricted cash ÷ [(operating expenses – noncash expenses) ÷ 365].

A. Regional Impact Assessment

» *Alaska State Budget:* Alaska relies on two main sources of revenue: (1) oil taxes/royalties and (2) federal funding for all state services to build and maintain the necessary infrastructure and increase cash reserves. The Alaska spring 2020 budget forecasts a $527 million reduction in projected Unrestricted General Fund revenue and a projected FY 2021 reduction of $815 million. Over 85% of the reductions are due to declines in projected petroleum revenue, which is largely a function of a lower oil price. Alaska North Slope revenue forecasts oil prices to remain below $30.00 per barrel for the remainder of FY 2020, resulting in an annual average price of $51.65 per barrel. The oil price forecast is based on oil futures and reflects the current extreme supply and demand imbalance gradually relaxing over the next several years. Ultimately, if oil prices and production remain below the annual spring forecast, the constitutional budget reserve will be empty after FY 2021.[20]

» *CBJ Budget:* In 2012, Moody's downgraded the CBJ from Aa2 to Aa3 as a reflection of weakened financial flexibility that resulted from consecutive years of draws upon reserves in the General Fund and other general operating funds. Cited as reasons that the rating would further decrease include

20 "Spring 2020 Revenue Forecast," Alaska Department of Revenue.

further declines in general fund reserves and declines in the tax base.[21] According to the CBJ FY 2020 Biennial Budget, by the end of FY 2022, the general fund balance will be down to a level that can no longer accommodate further draws.[22] The result will increase the cost of capital and require increased dependence on tax revenue.

April ended with an approximate loss in revenue of 50%, but BRH received two payments from the CARES Act that totaled approximately $2.0 million. BRH leadership estimates that net revenue for April will likely result in a total loss of $2.5 million. As of May, elective radiology and other procedures have reopened, resulting in revenue and patient day volumes increasing.[23]

Of BRH's yearly revenue, 6.5% is attributed to tourism (approximately $5.9 million), not including the revenue derived from local residents who are in the service and tourism industry. Therefore, COVID-19 will have an additional impact on BRH's revenue stream through the remainder of the year and potentially longer. As of May 2020, 479 Alaskan voyages with an estimated 955,784 passengers have been canceled, representing an 80% loss of expected voyages and 73% loss of expected passengers.[24] The impact on BRH's revenue stream is estimated at 10% to 15% of total revenue (approximately $11.3 million).[25]

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21 "Moody's Investors Final Report," Moody's, https://www.juneau.org/beta_transfer/assemblyftp/agendas/2012/2012-05-21_Special/documents/Moodys_Investors_Final_Report.pdf.

22 "Biennial Budget FY 2020," City and Borough of Juneau, https://3tb2gc2mxpvu3uwt0l20tbhq-wpengine.netdna-ssl.com/wp-content/uploads/2019/07/FY20-ADOPTED-Budget-Book-FINAL-for-INTERNET.pdf.

23 Ibid.

24 Government and Community Relations, Holland America Group—Princess Cruises, Holland America Line, and Seabourn.

25 "Budget Packet—FY 2021," Bartlett Regional Hospital, https://www.bartletthospital.org/media/38527/fy21-budget-packet.pdf.

V. Market and Strategic Position Overview

V. Market and Strategic Position Overview

A. Market Size and Competition

New population growth in the region is projected to be flat, with a compound annual growth rate (CAGR) of 0.48% from 2019 to 2024, largely driven by CAGR of 4.16% of the age 65 and over population. Low population growth in the under 65 age cohort indicates that in order to increase the patient base BRH will need to capture incremental market share from competitors or provide new or expand existing services. To grow BRH through developing new services, the hospital's leadership would likely need to offer services targeting the age 65 and over population or capture market share from established competitors by significantly differentiating BRH's service offerings, such as offering telehealth services for behavioral health and primary care and expanding clinic days for rotating specialties.

The primary competition in the Southeast Alaska market includes SEARHC and PeaceHealth in Ketchikan. SEARHC operates the Ethel Lund Medical Center in Juneau, which offers medical and dental clinics with physical therapy, radiology, laboratory, and pharmacy services, as well as scheduled specialty clinics that include ear, nose, and throat; pediatric; orthopedic; and other services (figure 5). SEARHC also owns 17 acres of undeveloped land less than one mile from BRH. BRH has limited competition for hospital-based services in the CBJ, but experiences significant patient leakage due to limited service offerings and acuity threshold.

Figure 5: Juneau Competitive Landscape

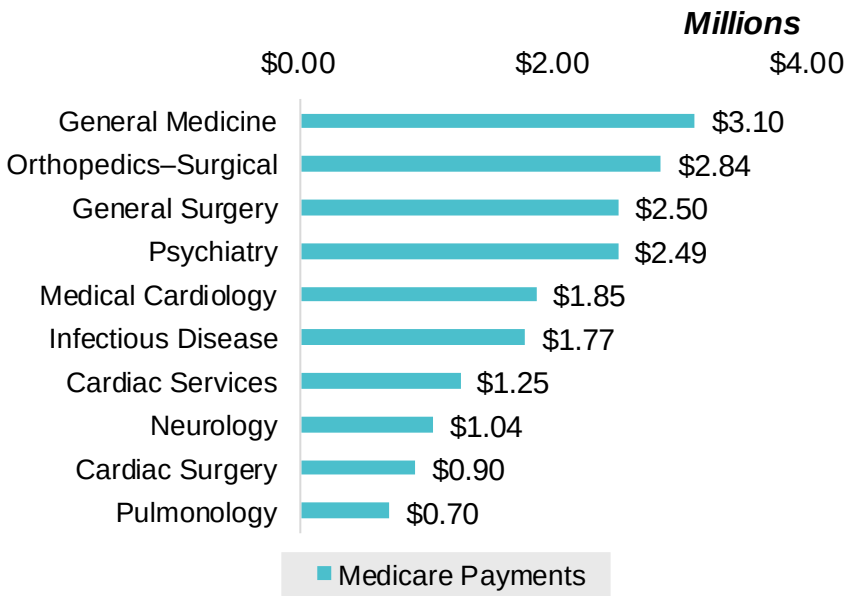
B. Leakage of Services

Physician shortages and geographic isolation contribute to low availability of services, including primary care and behavioral health. While the average rate of primary care physicians across the US is approximately 80 per 100,000 people, rural areas exhibit a much lower rate of 68 per 100,000 people.[26] The difficulty for rural residents to access services leads to the increased likelihood of costly, higher-acuity episodes of care. This increased likelihood, combined with prominent population growth in the age 65 and older cohort and current out-migration of Juneau patients to higher-acuity centers, indicates that the incremental capture of regional patients without new facilities or additional specialties will be difficult. BRH volume usually increases 12% to 15% over the summer due to tourism, but given the impact of COVID-19 and general state of the cruise industry, 2020 seasonal volumes will not reach historical levels.

Growth in the age 65 and older cohort will drive utilization for orthopedic and cardiology services. With approximately 17% of inpatient Medicare payments attributed to orthopedic surgery, orthopedics is expected to remain the highest-contributing service for BRH behind general medicine, as shown in figure 6.

[26] "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

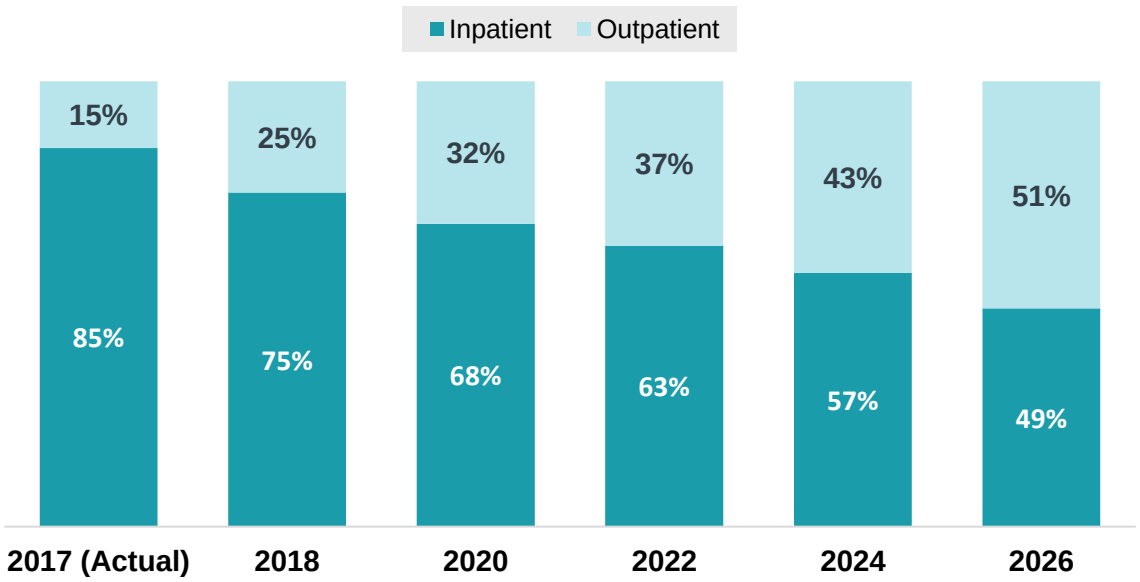
Figure 6: Inpatient Leakage by Specialty (Medicare only)[27]



Health systems and hospitals are feeling pressure from payers and their communities to reduce costs. In addition, changes in government regulations and among commercial payers reward providers for migrating high-acuity surgery to the ASC setting, which poses a financial threat to health systems due to the significance of surgical revenue. Improved surgical techniques are allowing more surgeries to move out of hospital inpatient settings and into ambulatory surgery facilities. In 2020, 32% of orthopedic joint replacements are projected to be performed in the inpatient setting, contrasted with 51% by 2026 (figure 7), representing a considerable financial risk to BRH.

[27] Definitive Healthcare, annual Medicare data is from CMS Medicare SAFs. The most recent annual Medicare data is from calendar year 2018.

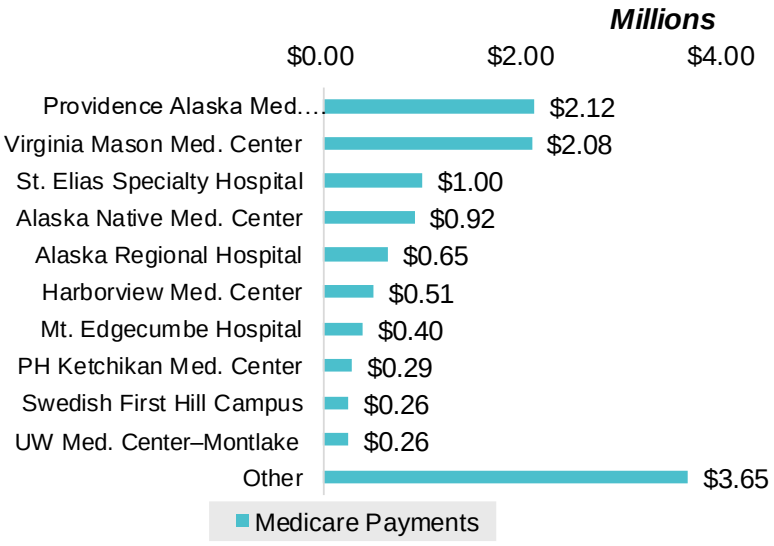
Figure 7: Projected Percentage of Joint Replacements by Care Setting



Based on estimates provided by SG2 (Vizient).
Source: https://www.bcbs.com/the-health-of-america/reports/planned-knee-and-hip-replacement-surgeries-are-the-rise-the-us.

Providence Alaska Medical Center in Anchorage and Virginia Mason Medical Center in Seattle split 35% of patient leakage, with total patient leakage in excess of $12 million, as shown in figure 8.

Figure 8: Inpatient Leakage by Facility (Medicare only)[28]



C. Physician Recruitment

Recruitment and retention of healthcare professionals in the rural setting has been and will continue to be a persistent challenge and costly endeavor for rural hospitals. While almost 20% of the US population lives in rural areas, fewer than 10% of US physicians practice in these communities.[29] Physician shortages and difficulty to recruit will be an ongoing issue, as a 2019 Merritt Hawkins survey of medical residents in their final year found, "only 1% of final-year medical residents surveyed would prefer to practice in a community of 10,000 people or fewer, and only 2% would prefer to practice in a community of 25,000 people or fewer."[30] The aging population of the CBJ exacerbates the issue. As the current physician workforce nears retirement, proactive efforts will need to be made to not only replace retiring physicians but recruit for growing specialties and service areas.

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28 Definitive Healthcare data based on the population of Medicare patients who had at least one claim at BRH (3,052 patients). The analysis evaluated those patients to determine where they go for care across all providers and across the entire continuum of care (hospitals, physicians, post-acute care).

29 "2019 Rural Report," American Hospital Association, https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.

30 "2019 Survey: Final-Year Medical Residents," Merritt Hawkins, https://www.merritthawkins.com/uploadedFiles/MerrittHawkins_Final_Year_Medical_Residents_Survey_2019.pdf.

VI. Summary Findings

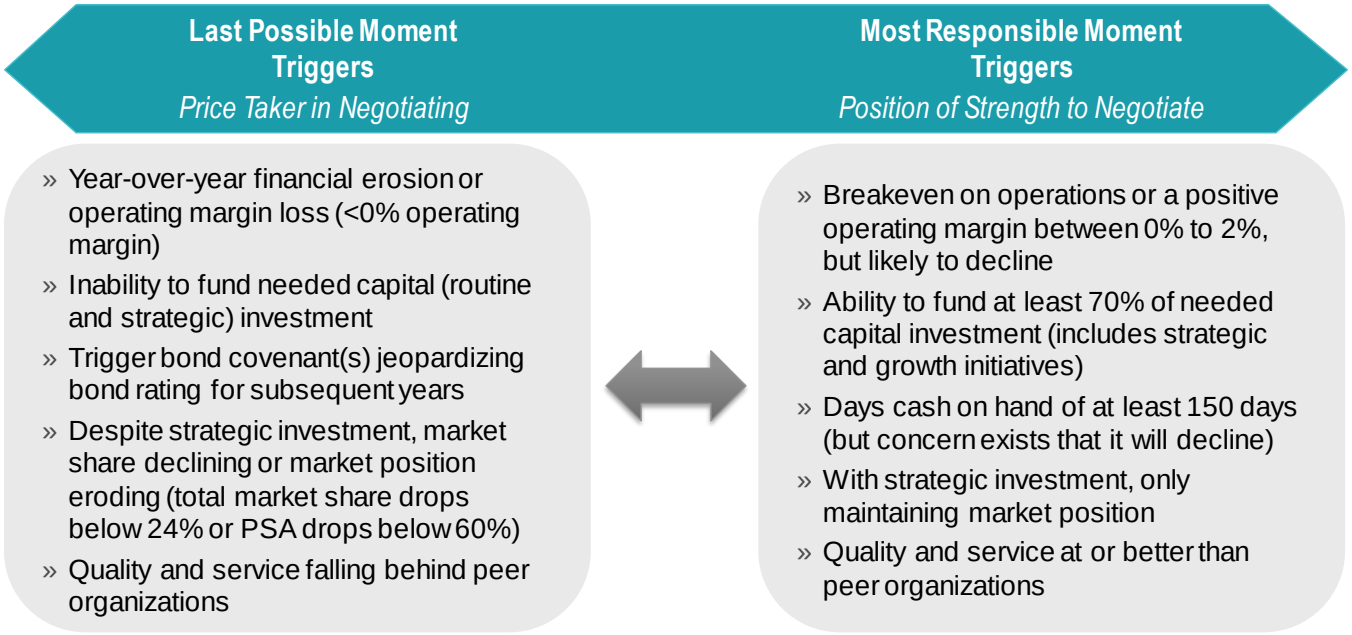
VI. Summary Of Findings

ECG's findings are based on BRH's current financial, market, and strategic performance and accounts for variables and trends predicted to impact the one- to three-year outlook of the organization.

A. The Most Responsible Moment

If an independent organization cannot fully execute its strategic imperatives, an affiliation or partnership may be necessary. ECG believes BRH is at its most responsible moment, as detailed in figure 9.

Figure 9: Assessing the Most Responsible Moment



B. Unstable Financials

BRH performs near the level of a Baa3-rated organization and has adequate capacity to meet its financial commitments. However, adverse economic conditions or changing circumstances are more likely to lead to a weakened capacity on BRH's part to meet its financial commitments. The oil industry accounts for one-quarter of Alaska jobs and about one-half of the overall economy when considering state spending.[31] Nearly 70% of Alaska's unrestricted general fund (UGF) is derived from petroleum revenues, which is budgeted to decrease by approximately $600 million in FY 2021.[32] As state funds continue to decline, the PERS obligation becomes a higher-risk liability. Additionally, financial support provided to the CBJ by the state will reduce future capital spending. Though BRH has significant cash

31 Kati Capozzi, "Oil and Gas," Home Page, www.akrdc.org/oil-and-gas#:~:text=Oil%20production%20has%20been%20the,in%20total%20revenue%20since%20statehood.

32 "Spring 2020 Revenue Forecast," Alaska Department of Revenue.

reserves, the current capital plan cannot be solely supported by operating cash flows, emphasizing the significance that the reduction in UGF (for the state and city) may have on BRH. Further, CMS's Rural Community Hospital Demonstration accounted for $4.8 million in revenue for BRH and is set to expire in June without a definitive decision in place regarding the future of the program. The net impact would effectively reduce BRH's operating EBIDA margin to 2.8%, leading to further dependence on cash reserves. Seasonal revenue growth derived from tourism will also continue to decline and lead to higher regional unemployment, as tourism is estimated to reduce BRH's revenue stream by 10% to 15%. Lastly, independent specialty care and imaging services entering the Juneau market will quickly undercut high-value BRH services, ultimately destabilizing BRH's financial position.

C. Change in Competitive Providers

Competitor incursion into the Juneau market has begun, with SEARHC having an established presence in the CBJ. SEARHC benefits from favorable government and tribal reimbursement, making narrow- or no-margin service lines sustainable and difficult for BRH to compete with. The most important factor of BRH's success is its status as the sole community provider in the market. Over the last three years, SEARHC has acquired medical centers, including Mt. Edgecumbe Medical Center in Sitka, proving its structural and operational capability to compete at the hospital level. Though BRH is not threatened by another hospital entering the market, SEARHC has 17 acres of undeveloped land on which to build facilities and expand offerings. The introduction of specialty care and imaging services would greatly diminish BRH's margin, as SEARHC would capture high-value cases.

D. Leakage of Services

New entrants or competitor partnerships will increase patient leakage, negatively impacting BRH's financials and eroding market capture. Changes in the current competitor footprint will quickly influence patient choice, and key specialty gaps at BRH will continue to create natural out-migration into other communities. A lack of local health plan incentives to stay in the community creates further out-migration as patients seek care outside the region. Stagnant population growth will continue to inhibit BRH's ability to backfill leakage with new patients.

E. Challenges to Recruiting

Physician recruitment is a national issue that is exacerbated in Alaska due to the fragmented landscape. The stark reality is that recruitment will only become more difficult going forward. Multiple barriers exist that limit the available talent in the recruitment pool, including geographic isolation, personal and professional isolation, and a lack of qualified candidates.

VII. Strategic Options and Recommendation

VII. Strategic Options and Recommendation

A. BRH Guiding Principles

Interviews with BRH stakeholders uncovered themes regarding the parameters and key tenets that any partnership will need to achieve in order for BRH and the CBJ to consider it a viable option.

- *Independence:* The CBJ will not consider selling the hospital.
- *Span of Control:* BRH wants to remain an independent organization capable of providing care locally and meeting ongoing capital investment needs.
- *Commitment to Southeast Alaska:* Any partner must be able to understand the unique aspects of providing care in Alaska and provide services that are suited to the region.
- *Commitment to BRH and the CBJ:* BRH and the CBJ do not want to become "lost" within a larger health system. The expectation is that these two entities will continue to influence how healthcare is delivered in Juneau.

B. Alignment Options

ECG does not envision significant alignment with local providers, but a broader alignment may blend elements from both physician and health system options.

Physician Alignment Options

- *Medical Directorship:* Financial agreement between a physician and healthcare organization in which the physicians provides service line leadership and participates in broader organizational strategy
- *Call Coverage:* Financial agreement between a physician and healthcare organization in which the physician provides on-call medical services for patients
- *Practice Management Services Organization (MSO):* Contractual relationship between a physician practice and an MSO to host administrative and management functions
- *Bundled Payments:* Reimbursement of healthcare providers on the basis of expected costs for clinically defined episodes of care
- *Comanagement Arrangement:* Contractual relationship between physicians and a hospital that results in a shared-responsibility management structure for a specific service line
- *Joint Venture (JV):* A commercial enterprise undertaken jointly by two or more healthcare organizations that otherwise retain their distinct identities

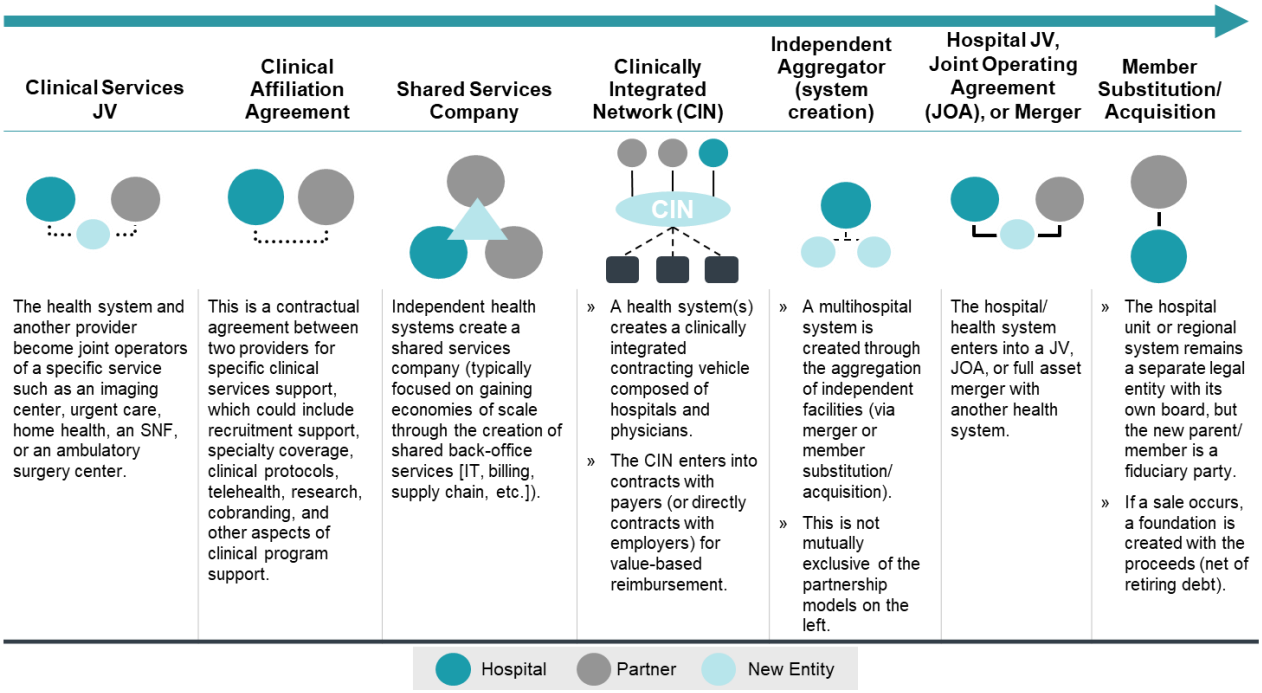
» *Professional Services Agreement (PSA):* Financial relationship between a physician practice and a hospital in which the physician practice remains an autonomous entity, but the physicians are compensated by the hospital at fair market value for their professional services

» *Full Employment:* Financial relationship between a physician practice and a hospital in which the physician practice is owned by the hospital entity, and the physicians are compensated by the hospital at fair market value for their professional services

Health System Alignment Options

Figure 10 depicts these types of options for BRH's and the CBJ's consideration.

Figure 10: Health System Alignment Options



C. Recommendation

Given the strategic positioning of the organization and in the context of BRH's guiding principles, ECG believes that the organization needs to select a model that allows it to stabilize and expand access to key services and physician specialties in the market while also retaining much of the autonomy that BRH has enjoyed since its opening. While there is no single option short of full integration on the spectrum outlined above that will fully insulate BRH from the competitive risks of incursion from a competitor such as SEARHC, selecting a model that addresses the following challenges will be key:

» Recruitment of physicians

» Leakage of services

» Access to expanded care options

To that end, ECG recommends BRH pursue a clinical service JV or clinical affiliation agreement with a provider that can bring a wider range of specialties and new services to the region while allowing the broader system to remain independent. This type of structure will provide BRH with a platform to address the need for specialists in the community as that need arises and potentially expand some services that patients currently have to travel for. The tasks outlined in table 4 will need to be undertaken in order to implement the recommendation.

Table 4: Implementation Tasks

Task 1	**Evaluate Services for Focus** Evaluate the spectrum of clinical services BRH currently offers, and discuss the long-term track record for success associated with the services. For each clinical service, assess the impact on BRH's ability to address the need for increased specialists in the community and expanded access for patients, relative to the current state.
Task 2	**Compile Profiles of Potential Partners** Assemble profiles of potential partners, including those organizations in the market and/or region that could potentially advance BRH's achievement of critical success factors and guiding principles. Potential partnership profiles typically include the following: » Corporate form » Ownership/sponsorship » Scope and scale of principal service delivery sites » Corporate infrastructure » Physician platform » Utilization trends » Market share trends » Key services and points of competitive differentiation » Financial analysis and credit profile » Consolidated financial analysis
Task 3	**Contact Potential Partners, and Develop RFP** Contact the partners identified in task 2, and develop an RFP for pursuing a clinical joint venture.
Task 4	**Evaluate Partnership Opportunities** Develop a detailed evaluation matrix and accompanying analyses that summarize the qualitative and quantitative factors to assess each potential partner. The framework would delineate the strategic alternatives available and the potential risk/rewards associated with each partner.
Task 5	**Conduct Deliberations** Facilitate a series of discussions with BRH and the CBJ leadership to review and discuss the partnership opportunities, interpret the implications, and reach consensus on the strategic direction for BRH.

From: Lisa Brandenburg
Date: November 13, 2020 at 2:20:11 PM AKST
To: "Charles E. Bill"
Subject: Thank you!

Dear Chuck

Thank you again for your time yesterday. Apologies for having to leave the call early but I was able to catch up with the team and we are quite excited about the opportunity to work with you.

It was exciting to hear of the growing strength of Bartlett Regional Hospital and your success in moving through the first COVID surge. With this continue strengthening, we understand the Board has determined it is a good time to seek a partner who could help in key areas, without change in ownership and/or economic integration. This is similar to successful affiliations we have with other health systems.

We are very excited at the potential opportunity to work with Bartlett Regional Health on the continued expansion of services for Juneau and outlying region. We understand you are viewing the opportunities in two large categories:

- Economies of Scale – GPO, IT and other support areas
- Enhanced Services – Expanded cardiology including the potential JV of a cath lab, closure of medical specialty gaps in the area of Neurology, Pulmonology, Infectious Disease, Rheumatology and Endocrinology among other opportunities

We will be assembling a team to understand how we might work with you on these topics and look forward to receiving the solicitation of interest and RFP.

Thank you,

Lisa

Lisa Brandenburg
President, UW Medicine Hospitals & Clinics
University of Washington
206.685.5020 | lisab@uw.edu

From: Charles Clement
Date: November 19, 2020 at 3:28:34 PM AKST
To: "Charles E. Bill"
Subject: Re: [EXTERNAL]Collaboration

Hi Chuck! Been meaning to reach out to you! I would love to explore these conversations, there is a lot of potential I think. Just let me know what time and format works for you. We have approached these exploratory conversations in various different ways in the past so I am very flexible.

Talk soon

Chuck

On 11/19/20, 10:31 AM, "Charles E. Bill" wrote:

Hi Charles,

As you may know, Bartlett has decided to explore the feasibility of partnering with another organization for economies of scale and expands specialty services in Juneau. We are in a strong financial position and are not interested in selling or losing local control but do see potential value to an expanded partnership.
Is this something that SEARHC would be interested in?

Affiliation Considerations

Chuck Bill:

1. 24/7 Intensivist CCU support.
2. Med Staff Peer review.
3. Expanded education opportunities.
4. Provider recruitment support.

What is in it for the partner?

1. Expanded referral network.
2. Branding presence in Juneau
3. Expanded GPO volumes.
4. First option for joint venture opportunities like Cath Lab.

Kevin Benson:

During my experience in a couple of different health systems what I found beneficial was the support for administrative departments. These departments could include Administration, Finance, PFS, HR, Compliance, HIM, IT, etc. The corporate office departments took care of keeping up with latest developments in their areas and then shared them to all locations through emails and monthly or quarterly meetings. As a stand-alone hospital each department needs to be constantly watching for new developments in the industry, interpret the change and figure out how to apply it. We have professional organizations that provide this type of information which is good, but we are still solely responsible for keeping up. A system that does this at a corporate level and then implements throughout the system provides greater confidence in the member organizations that they are doing the right thing. In addition, managers develop relationships with their peers, sharing common experiences and have less of a feeling that they are on their own.

Secondly, bringing in specialists to provide more services locally was very beneficial both for patients and the finances of the organization. The one thing local physicians get concerned about is once they make a referral sometimes they don't get the patient back for primary care. This needs to be delineated up front and monitored to prevent this from happening. It's probably less of a concern in Juneau but something to be aware of.

Billy Gardner:

1. Expansion of services through greater access to specialists
2. Access to Best Practice Protocols, Policies and Order Sets
3. Access to Ph.D. for research and research interpretation
4. Brand Image enhancements reflected in provision of service scores
5. Brand Image for Recruitment purposes
6. Beef up BRH teams with larger IT, Quality, department team access.
7. Materials, supplies, drugs, etc. ---- Greater ordering power and shipping costs as we align with an organization that has larger volumes. May give us greater opportunities beyond our GPO
8. Enhanced vendor access-- when we were searching for an EHR/EMR system Epic would not even look at us due to size. Affiliation will change this with many vendors
9. Legal team reviews from larger orgs
10. More options with Medivacs and care transition

Rose Lawhorne:

Needed

- Clinically integrated care delivery networking/specialty services support—cardiology, pulmonology, neurology, endocrine, critical care, neonatology (resuscitation effort participation/consultation), wound consults, oncology (until we build program successfully)
- Economies of scale impacts
    - Shared bargaining with payers
    - Purchasing power
- EHR improvements, modification and selection
- Education opportunities
    - Updated care models for staff and providers
    - Stable nursing school/provider (mid-level) training program
- Access to care protocols, EHR templates
- Shared resources (marketing, legal, compliance, staffing, etc.)

Offered

- Confidence in favorable financial operations, organizational stability/longevity
- Community coordination/communication
- Telemedicine hub for area wide coordination of care delivery
    - Consultation for specialty services
    - OB providers in discussions about partnering on a tele-NICU
    - Outpatient follow up services for acute patients upon return from affiliate facility
- Case management/care coordination
- Population health strategic collaboration
- Potential for swing bed capabilities for transitions to long term care or rehab
- Quality improvement programs that impact successful patient outcomes
- Local clinic/provider relationships that impact patient outcomes
- Transfer agreements/commitments
- Access to patient population data analytics
- Rural training experience location for med students, mid-levels

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Bradley Grigg:

Priorities:

- Child Psychiatry Consultation (with psychiatric providers and clinical therapists)
    - Psychiatric/Medically complex patients
    - Psychiatric/Developmental Disabilities patients

- Applied Behavioral Analysis Consultation:
    - Serving Youth on the Autism Spectrum

- Access to Clinical Training for:
    - Psychiatric Emergency Services and Crisis Intervention
    - Effectively treating Psychiatric/Medically Complex patients

Optional (as needed):

- Telehealth Support (Psych Assessment/Treatment Recommendations)
    - Inpatient
    - Outpatient