THE
University of Vermont
MEDICAL CENTER

January 21, 2015

Joyce Manchester
Senior Economist
Legislative Joint Fiscal Office
One Baldwin Street
Montpelier, VT 05633-5701

Re: Administrative costs inquiry

Dear Joyce:

Thanks again for reaching out to us for our views on administrative costs. You asked two questions:

1) How would we define administrative costs?
2) Which administrative costs might be reduced in the next couple of years?

You also included a list of categories used by the Green Mountain Care Board (GMCB) as part of their annual budget review cycle as a potential starting point for defining administrative costs, and asked for more detail about what is included in the general "administration" category.

Definition of Administrative Costs

How one defines "administrative costs" ultimately depends on the underlying purpose of the question. Broadly defined, administrative costs could be considered any expenses incurred by a health system, hospital or individual provider that do not directly involve patient care.

The GMCB list, which is similar to what appears on Medicare cost reports as overhead expenses, reflects this approach. While non-clinical in nature, a quick review of the list illustrates how intrinsic these services are to our ability to meet our mission of serving our community by delivering high-quality care, educating new health care professionals, and engaging in research that goes from bench to bedside.

The general "administration" category includes a variety of expenses ranging from executive leadership, integrity and compliance, community health improvement, community health teams, our employee wellness program, our employee and family assistance program, medical practice management, risk management, provider credentialing, marketing and communications, planning and business development, workers compensation costs, information security expenses, recruitment, volunteers, the gift shop, and most recently our expenses associated with accountable care (we are a founding member of OneCare Vermont, the statewide accountable care organization participating in all three existing shared savings programs).

It is important to note that a number of the expense categories on the GMCB list have offsetting revenues – pharmacy, cafeteria and parking are examples, as is our community health team, which is offset by Blueprint for Health funding. Others do not generate revenues in and of themselves, but represent investments necessary to deliver the type of high-quality care Vermonters both expect and deserve (quality improvement and systems efficiencies through the Jeffords Institute for Quality & Operational Effectiveness, for example). Still others are investments in Vermont's ongoing reform efforts, most notably those that support the development of population health management capacity through OneCare Vermont.

Potential Reductions in Administrative Costs

As a mission-driven, community-led nonprofit, the UVM Health Network (of which the UVM Medical Center is a part) is committed to reducing and eliminating unnecessary expenses in our system of care.

We use external benchmarks to help us understand how well we are performing in managing our expenses, primarily through benchmarking ourselves to other members of the University HealthSystems Consortium (UHC), an organization comprised of 98 academic medical centers around the country. The UVM Medical Center routinely falls into the lowest quartile of expenses in categories like patient care expense per adjusted discharge, patient care expense per patient day, and FTEs per occupied bed. Last year, we ranked the lowest among other UHC members in supply chain costs, and are second in that category for the most recent year measured (FY 2013). At the same time, we rank in the top twenty UHC institutions for quality of care and patient safety.

Recent examples of cost reductions, many of which could be seen as administrative costs, were shared with the GMCB during our latest (FY 2015) budget review, including:

- **Supply chain savings.** Since the formation of the UVM Health Network in 2011, savings in our supply chain costs total $5.8 million, with roughly $340,000 of that accruing to Central Vermont Medical Center and $1.9 million to the UVM Medical Center in 2014 alone.
- **Debt refinancing.** By virtue of being a member of the UVM Health Network, CVMC was able to restructure its debt in 2014 to avoid $512,000 in interest expenses.
- **Consolidation or coordination of services.** UVM Health Network members continue to explore and implement ways to reduce overhead expenses while standardizing operations across the system. Examples include:
    - The Jeffords Institute for Quality & Operational Effectiveness placed a Director of Quality at CVMC, and implemented the use of the UHC Clinical Database there, which will yield risk-adjusted comparable quality data that will guide quality improvement efforts systemwide.

- UVM Health Network planners have developed policies and processes for network business planning, and have built a UVM Health Network database infrastructure to support network planning needs.
- As reflected by our joint budget submission for FY 2015, UVM Health Network members have established a single budgeting process and network financial framework designed to support the system's capital needs over time.
- UVM Health Network members have consolidated their audit functions, contracting, reimbursement analytics, and treasury. We are in the process of consolidating credentialing and provider enrollment and have started discussions regarding consolidating some revenue cycle functions, such as coding and reporting. UVM Health Network controllers have begun work on standardizing our financial reports.

In addition to our own commitment to managing expenses, the budget review process used by the GMCB puts added pressure on all hospitals to reduce unnecessary costs. Expense management is a key part of achieving the margin necessary to support our operations (including our A-level bond rating) as the Board has imposed caps on revenue growth.

In terms of other potential reductions, some of our administrative costs are incurred in response to external forces, including the regulatory structures that govern our operations. Those range from credentialing requirements to accreditation requirements (both through CMS and The Joint Commission) to state-level requirements under the Medicaid program (for example, prior authorization requirements that impose paperwork requirements but rarely lead to service denials). To the extent those requirements can be reduced, streamlined or made consistent, it would help reduce some of our costs.

I hope this is helpful. We would be more than happy to meet with legislators or members of legislative staff to discuss this in more detail.

Very truly yours,

Meg H. O'Donnell
Director of Government & Community Relations and Assistant General Counsel