CCH / CountyCare

Cook County Health & Hospitals Committee Meeting

July 25, 2019

COOK COUNTY
HEALTH

Facts

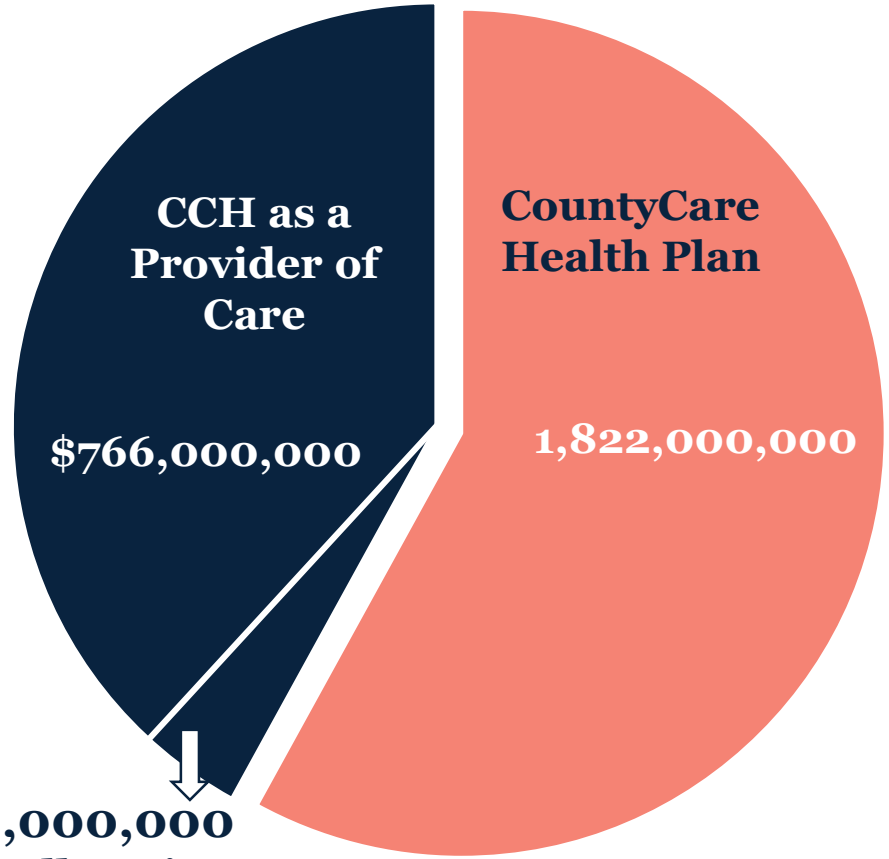
Cook County Health

- Cook County Health has developed successful strategies to fund its historical mission of providing care to all.
- Cook County Health receives less than 3% of its operating budget from local taxpayers. These funds are used exclusively for public health and correctional health. This reduction has allowed the County Board to reallocate nearly $3B since the Independent Board adopted its first budget in 2009.
- Cook County Health provides more than 50% of the charity care in Cook County and has absorbed growing charity care expenses without any additional local taxpayer allocation.

CountyCare

- CountyCare is certified by the National Committee for Quality Assurance (NCQA), the gold standard for health plans.
- CountyCare processes approximately 400,000 claims every month totaling more than $90M.
- According to the Illinois Department of Healthcare and Family Services, CountyCare has the fewest complaints from providers per 1,000 members.
- CountyCare has contributed more than $1B to the Cook County Health budget since 2013.

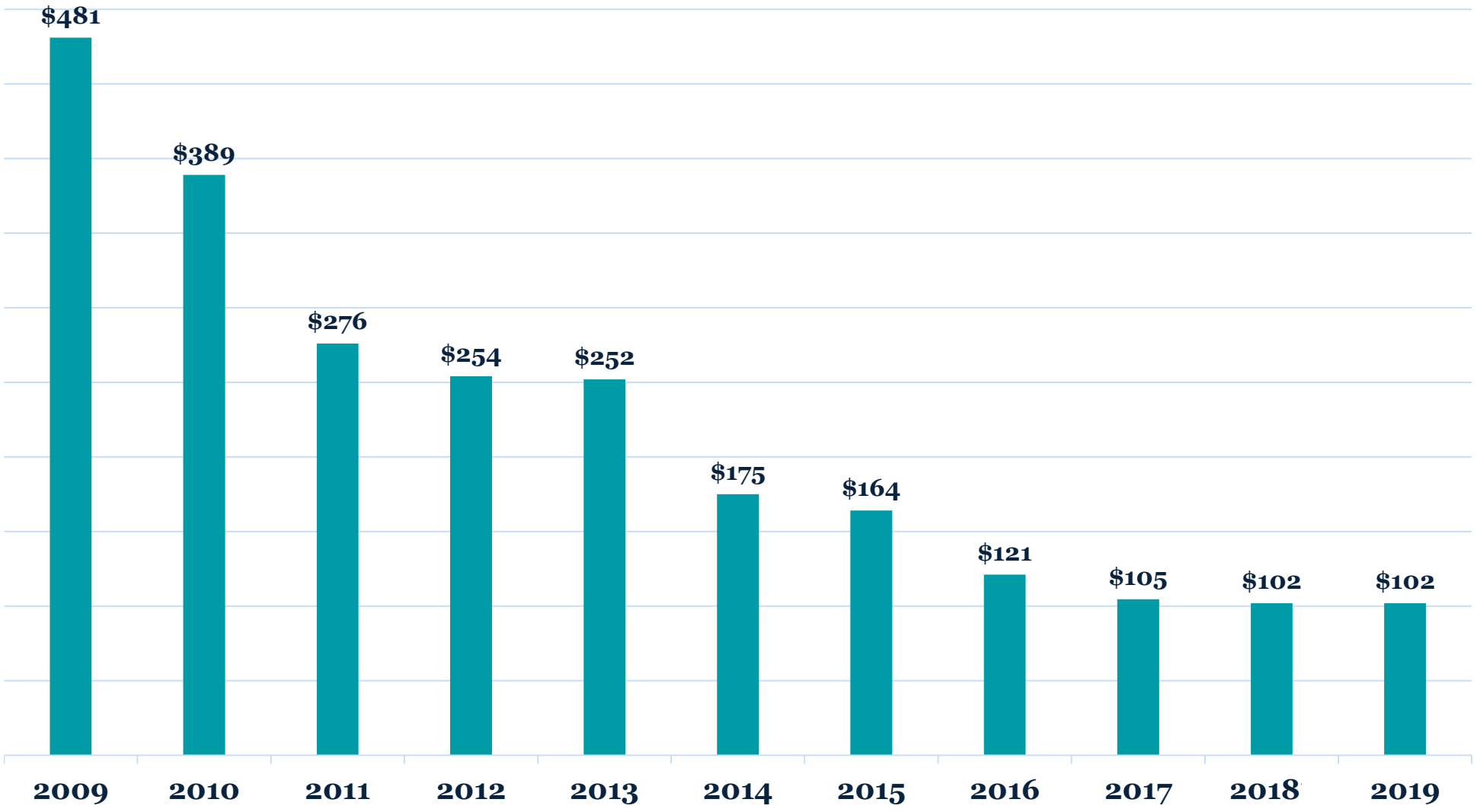
CCH FY2019 Budget inclusive of CountyCare



$102,000,000
Local taxpayer allocation toward operations
(Public Health & Correctional Health)

COOK COUNTY HEALTH

County Health Fund Allocation to CCH Operating Expenses (millions)



COOK COUNTY HEALTH

Charity Care in Cook County

	2013 Charity Care	% of all charity care	2017 Charity Care	% of all charity care	$$ Change 2013-2017
All Hospitals in Cook County	$690M	100%	$554M		↓ 20%
Stroger and Provident	$257M	37%	$296M	53%	↑ 15%

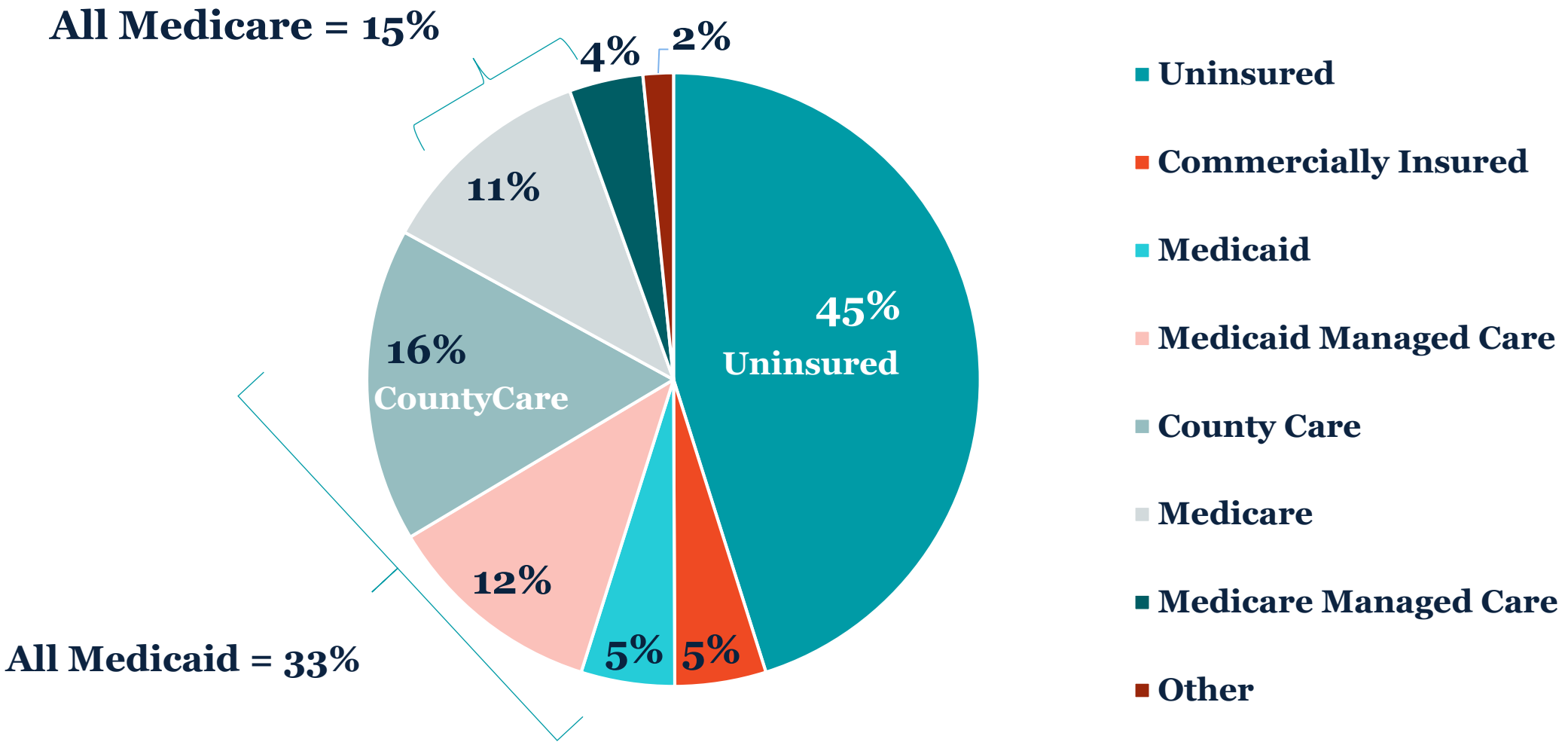
Source: IDPH Hospital Profiles 2013, 2017

NOTE: In FY2018, CCH provided more than $347M* in charity care, up 17% from FY2017. 2018 data for other hospitals has not yet been posted by IDPH.

*CCH FY18 Audited Financials

COOK COUNTY HEALTH

System Payor Mix By Visit (1Q2019)



COOK COUNTY HEALTH

Growth in CCH Bills and Charges Since 2013

Year	# of Bills	Charges*
2013	605,025	$ 1,194,462,952
2014	853,030	$ 1,214,116,755
2015	873,995	$ 1,285,993,170
2016	1,329,257	$ 1,521,277,744
2017	1,343,972	$ 1,609,546,426

*Charges – the price a hospital establishes for supplies, pharmaceuticals, services and procedures. Charges are contained in the hospital's charge master. A charge master is used as a data point for negotiations and is not reflective of what a hospital will ultimately receive.

CountyCare Claims Process & Safety Net Payments

COOK COUNTY HEALTH

Important Definitions

Received Claim – Claims received by the health plan after being billed by a provider

Adjudicated Claim – Claim that has been processed and determined if it meets required billing guidelines in order for the health plan to pay the claim

Paid Claim – Claim that has been adjudicated and paid

Denied Claim – Claim that has been adjudicated and denied for not meeting billing requirements

Payment Process for Claims

Provider

Turn-Around Time (TAT): Up to 180 Days

- Providers have 180 Days to Submit Claims to CountyCare
- Claim Determined Payable or Not Payable

CountyCare

FY18 Average TAT: 10 Days
Q1 FY19 Average TAT: 5 Days

- Payable Claims Batched and Sent for Processing
- CountyCare Submits Invoice to Cook County Health Accounts Payable

CCH Finance

FY18 Average TAT: 7 Days
Q1 FY19 Average TAT: 8 Days

- CCH Accounts Payable Enters/Approves, Submits to Cook County Health CFO for Approval
- Cook County Health CFO Approves, Invoice Goes to Cook County Comptroller for Review, Approval and Payment

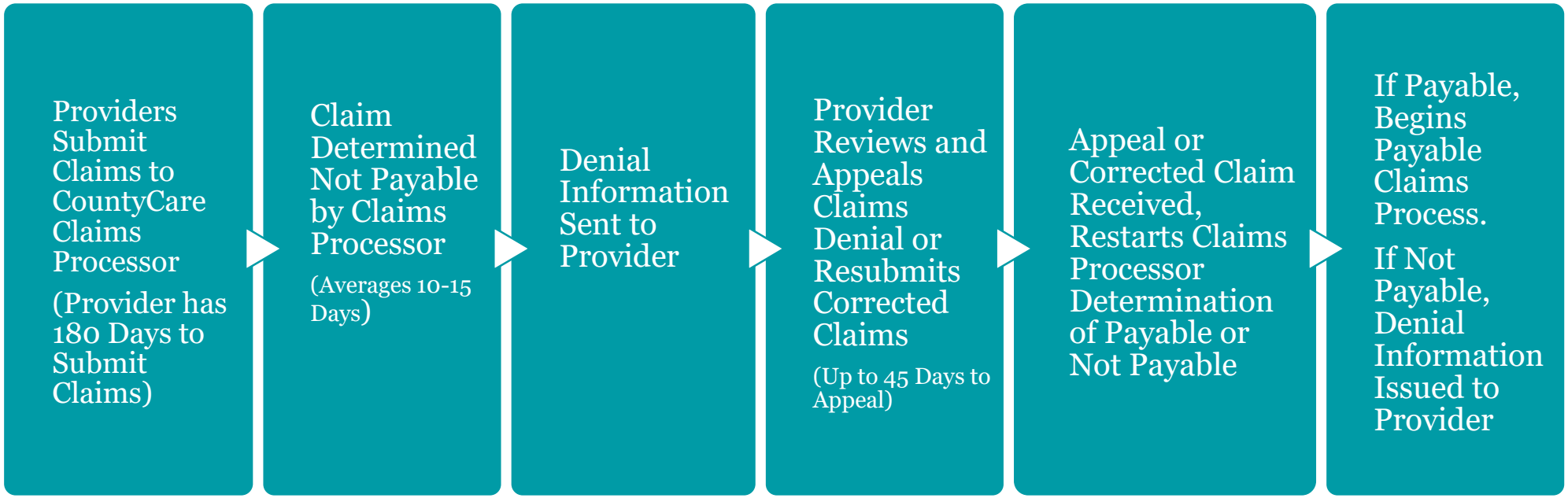
Cook County Comptroller

FY18 Average TAT: 8 Days
Q1 FY19 Average TAT: 11 Days

- Cook County Comptroller Approves, Moves to Queue for Payment
- Cook County Comptroller Issues Invoice Payment to Claim Processor
- Claims Processor Receives Funds and Issue Payments to Providers

Claims Denial Process

Denied Claim – Claim that has been adjudicated and denied for not meeting billing requirements



Top Reasons for Denials

- Claim received for individual covered by another plan
- Claim received for individual who is no longer Medicaid eligible
- Claim received that is a duplicate of a claim already submitted
- Improper coding of a claim
- Service required a prior authorization and was not obtained

State Capitation Payments for CountyCare

- CountyCare is currently owed $215M in capitation payments from the state of Illinois.
- CountyCare capitation payments are deposited directly into the County's bank account.
- Cash flow can impact timely payments to providers.

Payments to Safety Net Hospitals

In the past 12 months, 532 payments have been made to eighteen safety net hospitals in Cook County totaling $157,687,516.

Appendix

COOK COUNTY HEALTH

COMMONLY USED FINANCIAL TERMS

The County's Budget (or **Annual Appropriation Bill**) is prepared using a combination of each Basis of Accounting.

The County's **Comprehensive Annual Financial Report (CAFR)** is prepared in accordance with GAAP (Generally Accepted Accounting Principles) using the accrual basis of accounting for the government-wide financial statements and the modified accrual basis of accounting for the governmental fund financial statements.

Budget versus Actual Reports - The Corporate, Public Safety, Health and Special Purpose Funds Analysis of Revenues and Expenses reports actual monthly revenue and expenses compared to budgeted revenue and expense.

COMMONLY USED ACCOUNTING TERMS

Basis of Accounting describes the timing of recognition, that is, when the effects of accounting transactions (e.g., revenue or expenses) should be recognized.

Financial statements and budget reports often have different basis of accounting.

Audit Standards require audited financial statements be prepared on an accrual basis.

- This requirement is frequently referred to “as performed in accordance with Generally Accepted Accounting Procedures or GAAP”.

Cash Basis – This method recognized revenues and expenses when the cash is received or disburse

Accrual Basis - Method of accounting that recognizes and records accounting transactions for revenue when it is earned and expenses when they are incurred, regardless of the timing of related cash flows

Modified Accrual Basis - Method of accounting that recognizes revenues in the period in which they become available and measurable.

- Revenues are considered available when they will be collected either during the current period or soon enough after the end of the period to pay current year liabilities.
- Revenues are considered measurable when they are reasonably estimable.
- Expenditures are generally recognized when the fund liability is incurred.

Budgetary Basis – Method of accounting for governmental funds that is a combination of Cash plus Encumbrances and Modified Accrual Basis for revenues and expenditures and Accrual Basis for property taxes.

COMMONLY USED HEALTHCARE TERMS

Patient Accounts Receivable (PAR) - PAR represent the total **charges** for services provided by a health system. Because of contractual agreements, Medicaid, Medicare, Managed care and self-pay variances, the **PAR is not representative of what *any* health system will ultimately collect.**

Charge Master - All hospitals use a 'charge master' to define the initial list of charges set for thousands of supplies, pharmaceuticals, services and procedures. While the charge master is a data point for negotiations it plays a limited role (if any) in any payers reimbursements.

Contractual Adjustments - Contractual adjustments are the ***difference*** between rates billed to third party payer and the agreed-upon amounts that actually will be paid by the Payer.

Allowances - Allowances **include** contractual adjustments and bad debt for purposes of calculating net realizable value. An allowance is what a health system will **NOT** be paid.

Charity care – care provided by a health care provider for which the provider does not expect to receive payment from the patient or a third party payer.

COMMONLY USED HEALTH PLAN TERMS

PMPM – Per Member Per Month. This is used as a basis to review revenue and expenses adjusting for the number of members.

Billed Charges or "Gross" – Total amount billed by a provider to a health plan for services rendered to a member

Reimbursement or "Net" – Contractual amount to be paid for a given service by a health plan, typically this is significantly lower than the amount billed by a provider.

Received Claim – Claims received by the health plan after being billed by a provider

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Denied Claim – Claim that has been adjudicated and denied for not meeting billing requirements

Incurred But Not Received (IBNR) – Amount estimated of claims that will likely be received by the health plan in the future, for services already rendered but not yet billed by a provider. Providers have up to 180 days to bill a claim to the health plan.

Internal Capture – Amount of care being provided by Cook County Health to CountyCare members

Foreign Claims – Amount of claims related to CountyCare members receiving services outside of Cook County Health

Medical Loss Ratio – a ratio of total clinical expenses, as defined by contract with the State of Illinois Medicaid, divided by the total revenue of the health plan. Health plans are required to spend at least 85% of its revenue on clinical expenses.

Administrative Loss Ratio – Ratio of total administrative expenses divided by total revenue of health plan.