COOK COUNTY HEALTH & HOSPITALS SYSTEM

Finance Committee
Cook County Board of Commissioners

Ekerete Akpan
Chief Financial Officer, CCHHS
June 5, 2018

COOK COUNTY HEALTH & HOSPITALS SYSTEM
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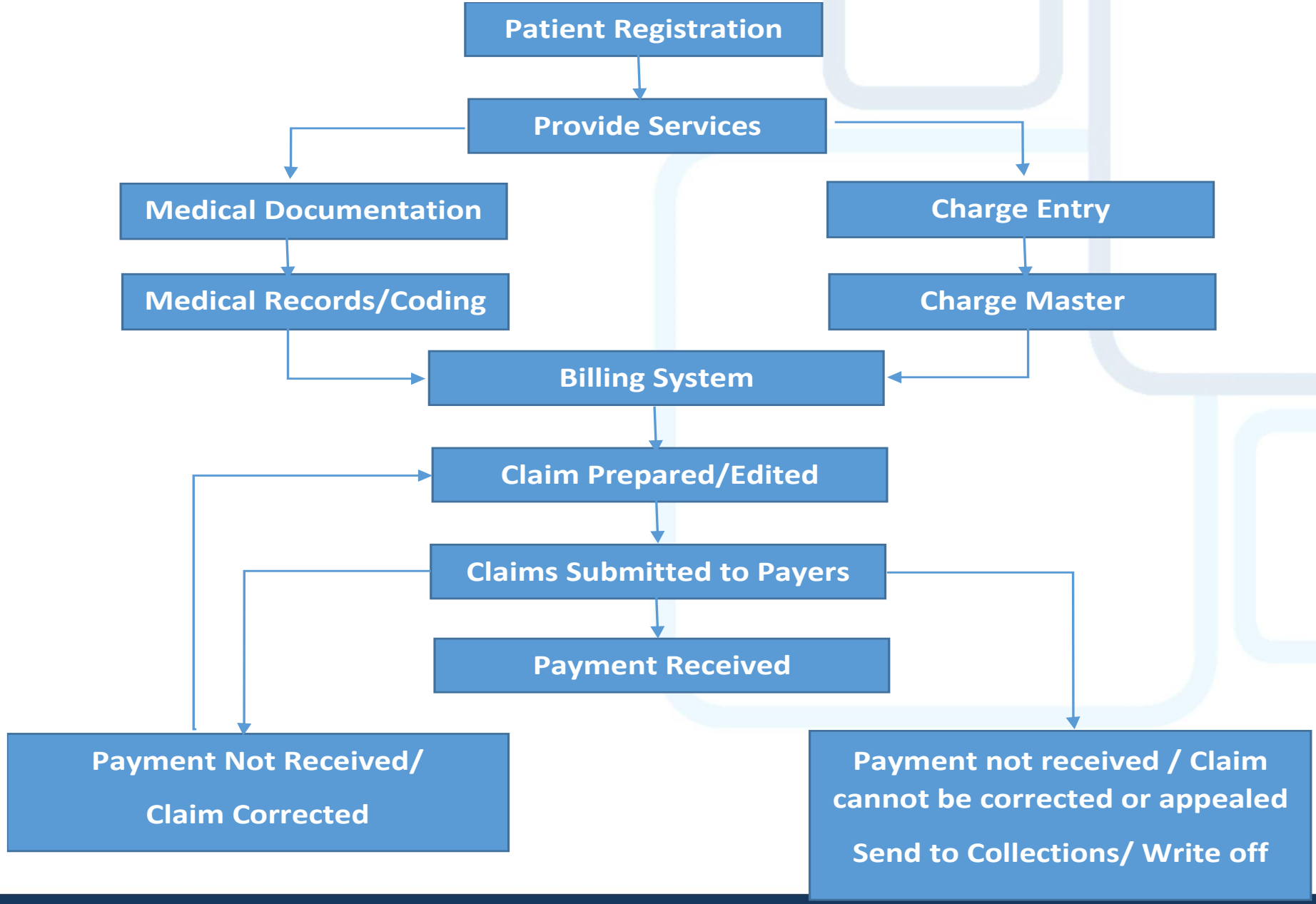
Revenue Cycle Management



Health Care Finance Rules & Regulations

There are a number of state and federal laws, rules and regulations regarding financial assistance, billing and collections that all health systems are subject to:

- **IRS Section 501(r) Financial Assistance Requirements**
- **Illinois Fair Patient Billing Act HB4999**
- **Hospital Uninsured Patient Discount Act (HUPDA) Public Act 95-965 and amended Public Act 97-690**

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Important Definitions

Term	Definition
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	Charity care discounts are reflected as charity.

How Gross Charges Roll-Up to the Patient Accounts Receivable Sample Scenarios

Payer Category	Commercial Insurers	Medicare/ Medicare Mgd Care	Medicaid /Medicaid Mgd Care	Self-Pay with 75% discount	Self-Pay with no discount
% of CCHHS Charges	4%	16%	42%	37%	
			79% of CCHHS Patients are Medicaid/Self-Pay		
Gross Charges	$5,000	$5,000	$5,000	$5,000	$5,000
3rd Party Payments	$3,600	$2,000	$1,000	$0	$0
Contractual Adjustments	$900	$2,300	$4,000	$0	$0
Charity	$0	$0	$0	$3,750	0
Patient Responsibility	$500	$700	$0	$1,250	$5,000
Patient Payment	$500	$700	$0	$500	0
Bad Debt	$0	$0	$0	$750	$5000

Payer Categories: Commercial Insurers, Medicare, Medicaid and Self-Pay represent the majority of CCHHS payer groups.

Timeline of a Bill

Medicaid Fee-For-Service or Medicaid Managed Care Organization

1. Patient is registered
2. Services rendered
3. Bill sent to Medicaid or MCO for $5,000
4. MCO could
   - Reject bill - adjust & resubmit
   - Adjudicate and deny bill with reason – using denial management, often requires appeal, corrections further documentation
   - Could pay contracted amount (not billed amount)
5. Medicaid FFS could
   - Adjudicate
   - Deny bill with reason
   - Pay encounter rate/amount
6. Unpaid balance is treated as Contractual Adjustment &/or written off

Self-Pay Bill

1. Patient is registered
2. Services rendered
3. Bill sent to patient for $5,000 on day 65
4. If not collected by day 96, patient receives 2nd bill
5. If not collected by day 127, patient receives 3rd bill
6. If not collected by day 160, referred to collection agency
7. Collection Agency collects or is unable to collect
8. If unable to collect, CCHHS writes off $5,000 and removes value from the PAR.

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Gross Accounts Receivable

- the total of uncollected gross charges for all accounts at any given time

Minus

Allowance Amount

- based contractual terms, contracted payers, Medicaid and Medicare rates and past experience of self-pay collections

Equals

Net Realizable Value

- the amount CCHHS realistically expects to collect from insurers and patients

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RSM

FY16 Audited Financial Report

Receivables: Patient Accounts – net of allowances of $271,531,805 in 2016 = $84,793,838

Cook County Health and Hospitals System of Illinois

Statements of Net Position
November 30, 2016 and 2015

	2016	2015
Assets		
Current assets:		
Cash and cash equivalents (Note 5):		
Cash in banks	$ 2,837,518	$ 1,569,541
Cash held by Cook County Treasurer	255,632,615	341,965,251
Working cash fund	95,147,154	95,147,154
Total cash and cash equivalents	353,617,287	438,681,946
Property taxes receivable - net of allowance of $8,381,170 in 2016 and $5,835,492 in 2015:		
Tax levy - current year	121,235,196	149,756,021
Tax levy - prior year	5,239,354	1,483,304
Total property taxes receivable	126,474,550	151,239,325
Receivables:		
Patient accounts - net of allowances of $271,531,805 in 2016 and $250,451,807 in 2015	84,793,838	67,233,873
Due from State of Illinois - CountyCare (Note 16)	45,786,270	51,750,784
Capitation receivable (Note 17)	43,442,900	55,771,662
Third-party settlements	2,817,381	3,830,072
Due from other County governmental fund	4,893,585	-
Other receivables	12,346,982	9,106,023
Total receivables	194,080,956	187,692,414
Inventories	4,023,099	4,438,429
Total current assets	678,195,892	782,052,114
Refundable deposit (Note 16)	25,000,000	-
Capital assets, net of accumulated depreciation (Note 6)	397,363,422	394,977,522
Total assets	1,100,559,314	1,177,029,636
Deferred outflows of resources:		
Pension related amounts (Note 10)	659,063,246	93,364,101

CCHHS Actions/Responses

IIG Recommendation	CCHHS Actions / Responses
1. Denials Prevention, Staffing, Quality Review	• *Denials management is an issue faced by every hospital.* • *Illinois' mandated Medicaid managed care has heightening denials management challenges.* • *In 2016 CCHHS' strategic plan "Impact 2020" addressed the need to invest and build capacity.* • *In Q3-2017 CCHHS included 15 new positions in quality assurance, registration, coding and billing as part of the FY2018 proposed budget. These positions are in various stages of the hiring process.* • *In Q4-2017 CCHHS created a Denials Management Task Force to review processes. The DM Task Force regularly reports to CCHHS' Utilization Management Committee.* • *In the last 6 months CCHHS engaged a consultant with expertise in denials management to supplement existing internal efforts.* • *CCHHS saw improvements in FY18 and expects that to continue and strengthen.*
2. Performance Standards, Employee Accountability, Vacancies & Staffing	• *CCHHS is bound by the terms of Collective Bargaining Agreements (CBA's) and performance standards must be negotiated with labor.* • *In 2017 CCHHS negotiated performance standards in Billing and memorialized them in a Memorandum of Understanding (MOU) that has been actively implemented.* • *Progressive discipline is implemented for employees not meeting the MOU's standards.* • *In Registration there is a process of training, evaluating and re-training and re-evaluating as needed; discipline is implemented after staff is provided sufficient opportunity to succeed.* • *CBA's, the Shakman Consent Decree and the court-approved Employment Plan govern CCHHS' processes for filling vacancies and can slow the time to hire.* • *In April 2018 CCHHS issued a Request for Proposals (RFP) for supplemental staffing over the next several months while we onboard and train new staff.*
3. Insured Non-Emergency Services Policy, Provider Reimbursement Education	• *CCHHS' mission is to provide care to all who need it regardless of their ability to pay.* • *If we determine that a patient needs a certain level of care, we will provide that level of care and seek to work with the insurer to justify and get reimbursed for the care.* • *CCHHS is working with our medical staff and authorization team to follow pre-authorization processes as defined by the various Managed Care Organizations (MCOs) to improve payments.*

CCHHS Actions/Responses

IIG Recommendation	CCHHS Actions / Responses
3. (Continued)	• *CCHHS is implementing strategies to reduce unnecessary tests and procedures and to document necessary tests and procedures to alleviate denials.* • *CCHHS is redirecting patients to other providers or facilities if CCHHS is not in-network for their plan.* • *CCHHS is adding staff to increase our abilities in this area.* • *Each insurer/MCO has their own appeal process, many of which are intentionally laborious.* • *It is not unusual to 'meet the rules' and still be denied reimbursement which triggers an appeal process.*
4. Accurate & Timely Clinical Documentation, Oversight, Discipline	• *CCHHS physicians and medical professionals DO complete medical documentation.* • *Prior to the ACA, the Medicaid reimbursement process did not require CCHHS' medical staff to document for billing purposes because the small number of insured patients did not justify the expense of creating sophisticated billing systems that recognize the International Classification of Diagnoses (ICD) codes universally used in the healthcare industry.* • *Since the ACA, CCHHS has started to build this new and required billing infrastructure.* • *In October 2015, the number of ICD codes increased exponentially. The complexity of the new coding requirement has challenged hospitals across the nation to retain and recruit skilled staff to submit accurate bills that do not result in denials.* *Procedure Codes increased from 3,824 to 71,924* *Diagnosis Codes increased from 14,025 to 69,823* • *CCHHS continues to prioritize these matters providing appropriate support and training to our medical staff prior to proceeding to discipline.* • *CCHHS is also investing in technology solutions to streamline processes including coding, clinical documentation and Cerner patient accounting.*
5. Scheduling, Training, Pre-Authorization, Denials	• *CCHHS has been phasing in a centralized registration process over the past six months that will be completed later this year.* • *The new central registration process will provide a much improved experience for patients.* • *The new process will also allow for the standardization of registration.* • *CCHHS intends to continue and strengthen training for all who register and schedule patients .* • *See above responses related to training and denials.*

Timeline of Activities Impacting Revenue Cycle

2013
- CCHHS 1115 Waiver program begins allowing CCHHS to early enroll newly eligible individuals into Medicaid managed care
- CCHHS begins to build CountyCare Infrastructure and Membership

2014
- Affordable Care Act (ACA) launches nationwide.

2015
- State Rollout of Mandatory Medicaid Managed Care in Cook County. Illinois Medicaid Expansion with 650,000 new members
- CCHHS 1115 Waiver Ends & State Contracts with CountyCare to expand to all Medicaid populations. CountyCare is one of fourteen Medicaid managed care plans the state contracts with.
- → CCHHS expands billing infrastructure and begins to contract with other MCOs to serve as a provider in other plans.
- → Coding Transition from ICD-9 to ICD-10. Federally mandated change increases number of codes from less than 20,000 to more than 140,000. Qualified Coders become difficult to recruit across the healthcare industry.

2016
- → CCHHS Strategic Plan is adopted and addresses need to build greater capacity in billing, coding and denials management
- CCHHS FY17 Budget adopted. Priorities include billing, coding and denials management.

2017
- Year one of CCHHS Strategic Plan
- → CCHHS & labor agree to MOU re: billing and performance standards. Training, evaluation & progressive discipline begins.
- CCHHS expands Denials Management capacity with internal and external resources.
- CCHHS continues to invest in Technology Solutions including coding, clinical documentation & Cerner patient accounting.
- CCHHS FY18 Budget adopted. Priorities include new positions in registration, billing and coding.

2018
- Year two of CCHHS Strategic Plan
- → Illinois Department of Healthcare and Family Services launches HealthChoice Illinois resulting in disruption in the market, contraction to 7 MCOs operating in Cook County and a first-ever choice period. CountyCare grows to 330,000+ members.
- Additional Registration, Coding & Billing positions posted.
- → CCHHS now contracted with all MCOs in Cook County in addition to appropriate pharmacy, dental, vision benefit managers.
- CCHHS Issues RFP to 'sell' Accounts Receivable. No Responses Received.
- CCHHS Issues supplemental billing and coding staffing RFPs until new staff can be on-boarded and trained.

Discussion

References to CCHHS Revenue Cycle in CCHHS Strategic Plan IMPACT 2020

Adopted by CCHHS Board of Directors on July, 29, 2016
Approved by the Cook County Board of Commissioners on November 15, 2016

- "…Like other health systems, CCHHS continues to build its internal capacities and infrastructure to succeed in the complex managed care environment, from pre-authorizations to billing…" (page 17)
- "...Continued efforts to improve clinical documentation and billing…" (page 21)
- "…Continue outreach to MCOs to increase the number of contracts..." (page 23)
- "…Continue to review and improve operations and processes to maximize reimbursement from MCOs…" (page 23)
- "…Improve billing by reconciliation of clinical registrations and billing system output…" (page 23)
- "…Improve provider documentation to support coding and billing to reflect the level of service provided…" (page 24)
- "…Provide tools for providers to collaborate with HIM to achieve chart completion and coding queries to support timely billing…" (page 24)
- "…Provide coding support to providers…" (page 24)
- "…Conduct utilization management review of claims…" (page 24)

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APPENDIX

COOK COUNTY HEALTH & HOSPITALS SYSTEM

COOK COUNTY HEALTH & HOSPITALS SYSTEM
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April 9, 2018

Mr. Patrick M. Blanchard, Inspector General
Office of the Independent Inspector General
69 West Washington Street, Suite 1160
Chicago, IL 60602

Dear Mr. Blanchard,

This letter is in response to your report dated March 22, 2018. The Cook County Health & Hospitals System, like other hospitals in the state of Illinois, has been building the billing and collections infrastructure to successfully operate within the state of Illinois' new Medicaid managed care environment. This has required significant work from the negotiation and approval of contracts with dozens of entities from managed care organizations (MCOs) to pharmacy benefit managers to the programming of systems to distinguish the nuances between all the accepted plans to ensure proper plan identification for patients at registration, pre-authorizations, claims and appeals processes.

Following the implementation of the Affordable Care Act and practically overnight, CCHHS' payer mix went from 70% uninsured to 60% insured. In the pre-ACA environment, nearly 100% of the insured patients were covered by Medicaid at a time when we were operating in a fee-for-service, encounter or per diem reimbursement environment. We would bill Medicaid for every encounter, procedure or hospitalization and the state Medicaid agency would reimburse us. Today's environment is quite different, requiring contracts with other MCOs and negotiating rates – a situation all hospitals serving Medicaid beneficiaries in Illinois are undergoing. Since the adoption of managed care for Medicaid enrollees in Illinois, hospitals have been hiring billing, coding and collections staff at a frenetic pace to keep up with the rules around each contract they have. You will recall this was part of the reason the state of Illinois rebid its managed care contracts last year – hospitals were having a hard time navigating the 13 different plans that were operating in Cook County. Today, that number is down to seven but nonetheless each year, hospitals renegotiate the terms of their deals with MCOs.

In CCHHS' three-year (2017-2020) strategic plan, *IMPACT 2020*, Objective 3.1 states "Maximize reimbursements from Managed Care Organizations and private insurance and compete on value, grow membership and influence MCO strategy." Specific tactics within this objective include:

- Continue outreach to MCOs to increase the number of contracts.
- Continue to review and improve operations and processes to maximize reimbursements from MCOs.
- Conduct utilization management, claims payment and reporting to support MCO contracts.
- Improve billing by reconciliation of clinical registrations and billing systems output.

Since the adoption of the Strategic Plan and as you report, we have experienced a 40% decrease in write-offs between 2016 and 2017 – an accomplishment we are proud of but one that needs continued effort. As we explained in our November 15, 2017 letter to Commission Boykin (attached), presented to the Finance Committee of the Cook County Board of Commissioners on January 17, 2018, and as reported in the County's external audit, it is critical to note that the dollar figures you note are *charges* and not *net realizable cash*.

As such, the amounts are significantly more than what we (or any hospital) would collect in an even perfect scenario. We would also call your attention to the nearly 20% of your amount in 2017 that relates to non-covered services. Fundamental to our mission is to provide what patients need regardless of ability to pay, and this impacts decisions made by our physicians. An example of this is tattoo removal. While a number of the MCOs refuse to cover this service we know that removal of gang tattoos is often an essential part of people being able to change the trajectory of their lives. We will continue to provide these – and other services - that we deem are in the best interest of our patients, even if the service not covered by their plans.

Hospitals across the country are experiencing increased challenges around revenue cycle, cash flow, patient collections and denials. See Hospitals Write Off 90% More Claim Denials.

In response to your specific recommendations:

1) HHS should heighten its focus on claim denial prevention and require additional personnel to provide quality control measures at the different stages of the Revenue Cycle. HHS should assess the current quality review process and implement modifications that will identify problems before they are submitted to Payers for payment. This should include expanding on the practices currently being used in patient registration and training. The increase in personnel costs should be minimal compared to the amount of claim denials HHS experiences each year. This includes implementing system restrictions to prevent personnel from creating duplicate Financial Information Numbers.

   CCHHS Response:

   It is important to reiterate that denial management is an issue that every hospital faces, a challenge that has grown in Illinois since the mandatory Medicaid managed care strategy went into effect. CCHHS brought in an outside expert to work with us on denials approximately 6 months ago. We have added 15 positions in the areas of quality assurance, registration, coding, and billing. These positions are in various stages of hiring/recruitment, thus we expect to see marked improvement this calendar year.

2) HHS should expand and enforce the performance standards for all employees who participate in or affect the revenue cycle process. HHS management and supervisors should hold employees accountable for their actions and institute appropriate discipline training or preferably a combination of both for repeated errors that result in revenue loss. HHS should fill open positions in the Revenue Cycle Department with qualified new hires. Moreover, current employees without the necessary skill set or self-motivation to meet the minimal performance standards should be replaced.

   CCHHS Response:

   Performance standards must be negotiated with labor leaders. While the IIG appears to be advocating unilateral actions, CCHHS is bound to the terms of various collective bargaining agreements. We have negotiated standards in the billing area and are utilizing progressive discipline for those not meeting standards. In registration, we have a process of training and evaluating and retraining and reevaluating if needed. After sufficient opportunity is made available to the staff to succeed, we proceed to discipline. As the IIG knows, we are required to follow the requirements of both the Shakman Decree (and our Employment Plan) and the Collective Bargaining Agreements in filling open positions which can slow our hiring process. We have a Request for Proposals for supplemental staffing that was posted in the first week of April to augment current employees while we onboard and train new staff. We anticipate an evaluation of respondents and a recommendation to our board for related services as early as our May board meeting.

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3) HHS should re-evaluate its current policy that provides non-emergency healthcare services to insured patients whose insurance companies will not pay HHS. Similarly, HHS, while always mandating the delivery of appropriate medical care, should seek to better align and/or educate its medical providers with the guidelines prescribed by Payers for the selection of reimbursable medical treatments.

CCHHS Response:

The mission of CCHHS is to provide care to all who need it regardless of their ability to pay. If we determine that a patient needs a certain level of care, we will provide that level of care and seek to work with the insurer to justify and get reimbursed for the care. We are working with our medical staff and our insurance authorization team to follow pre-authorization processes as defined by the various MCOs to improve payments in this area. It is important to note that it is not unusual to 'meet the rules' and still be denied reimbursement, which triggers an appeal process. Each insurer/MCO has an unique appeal process, many of which are intentionally laborious.

For quality and safety reasons, we always strive to reduce unnecessary tests and procedures, and to document the clinical indication for necessary tests and procedures to minimize denials. Additionally, when clinical circumstances allow we redirect patients to other providers or facilities if CCHHS is not in-network for their plan. As with other dimensions noted above, we are adding staff to increase our effectiveness in this area.

4) Senior management should emphasize to physicians and other medical professionals the importance of accurately completing patient medical records in a timely fashion. This should include implementing additional oversight measures and the imposition of discipline for routine failures to meet these deadlines.

CCHHS Response: *It is critical to note that physicians and other medical professionals **are** completing medical documentation related to the provision of healthcare. The documentation issue that the IIG is raising is that while CCHHS physicians have always documented details needed for safe care and regulatory requirements, many of CCHHS' medical staff have never been required to document to justify care to a payer for billing purposes. This is because previously we had too small a population of insured patients to justify the expense of creating sophisticated billing systems that recognize the International Classification of Diagnoses (ICD) codes which are universally used in the healthcare industry.*

	ICD-9-CM	ICD-10 code sets
Procedure	3,824 codes	71,924 codes
Diagnosis	14,025 codes	69, 823 codes

	Old	New
Diagnosis Structure	ICD-9-CM • 3 -5 characters • First character is numeric or alpha • Characters 2-5 are numeric	ICD-10-CM • 3 -7 characters • Character 1 is alpha • Character 2 is numeric • Characters 3 – 7 can be alpha or numeric
Procedure Structure	ICD-9-CM • 3-4 characters • All characters are numeric • All codes have at least 3 characters	ICD-10-PCS • ICD-10-PCS has 7 characters • Each can be either alpha or numeric • Numbers 0-9; letters A-H, J-N, P-Z

At the same time CCHHS initiated this new infrastructure, the number of ICD codes increased exponentially (see table). The complexity in this new coding requirement has challenged hospitals across the nation to retain and recruit skilled staff and submit accurate bills that do not result in denials. It should also be noted that organizations that do this most effectively are working with a far more favorable payer mix, such that the expense of coding assistants more than pays for itself.

CCHHS continues to prioritize these matters providing appropriate support and training to our medical staff before we proceed to discipline.

5) HHS should ensure that physicians and nurses receive the necessary training to appropriately schedule patient appointments. It should also work closer with the Managed Care Department to avoid claim denials based on the absence of pre-certifications, pre-authorizations and non-covered services provided to insured patients.

CCHHS Response:

See above responses. It is our intention to remove highly trained professionals from scheduling. We have been phasing in a centralized registration process over the past six months that will be completed later this year and provide a much improved experience for our patients, who currently may need to call multiple departments to schedule appointments. Additionally, this process should allow for the standardization of scheduling and registration, which will enhance critical steps such as identification of payer, need for pre-authorization and so on.

In closing, CCHHS is extremely proud of how quickly we have responded to the changing environment following the implementation of both the Affordable Care Act and specifically Medicaid managed care in Illinois. The points that your report identified, though mischaracterized in scale, were in fact predicted and discussed in great detail during CCHHS board and committee meetings over the past several years. They have been strategic priorities with specific individuals and teams working to address them for some time. CCHHS looks forward to continued improvement in performance in all dimensions of revenue cycle success, and the further maturation of these systems as we continue to carry out our mission to serve vulnerable populations.

Sincerely,

John Jay Shannon, MD
Chief Executive Officer