

Toni Preckwinkle

President

Cook County Board of Commissioners

John Jay Shannon, MD Chief Executive Officer

Cook County Health & Hospitals System

Board Members

M. Hill Hammock Chairman

Commissioner Jerry Butler Vice Chairman

Mary Driscoll, RN, MPH Ada Mary Gugenheim Emilie N. Junge David Ernesto Munar Robert G. Reiter, Jr. Mary B. Richardson-Lowry Layla P. Suleiman Gonzalez, PhD, JD Sidney A. Thomas, MSW

Austin Health Center Cermak Health Services Children's Advocacy Center Cicero Health Center Ruth M. Rothstein **CORE** Center Cottage Grove Health Center CountyCare Health Plan Englewood Health Center Logan Square Health Center Morton East Adolescent Health Center Near South Health Center Oak Forest Health Center Dr. Jorge Prieto Health Center Provident Hospital Cook County Department of Public Health Robbins Health Center John Sengstacke Health Center John H. Stroger, Jr. Hospital Vista Health Center

Woodlawn Health Center

November 7, 2018

Honorable John P. Daley Chairman, Committee on Finance Cook County Board 118 N. Clark Street, 3M Chicago, IL 60602

Dear Chairman Daley,

Below please find the responses to Commissioner Garcia's inquiry from October 24, 2018.

Please define what staff and expenses are included in County Care Administrative Expenses? How does your 4.6% Administrative cost level (e.g. \$83M out \$1822M) compare to other insurers?

CountyCare's administrative costs are specific to the Medicaid managed care plan and include payment of claims and administrative costs associated with the state contract, provider agreements, actuarial services, etc. These administrative costs do not include CCH's administrative costs. CountyCare contributes to CCH's overall costs by paying for services provided to CountyCare members at CCH Facilities.

CountyCare has the lowest administrative cost compared to every other Medicaid managed care plan operating in the state of Illinois.

2. What are you doing to improve billing so as to recover more expenses?

Like all healthcare systems, CCH has had to adjust to changes in the reimbursement landscape with the transition of the state's Medicaid program from its historical fee-for-service operation to managed care. CCH identified challenges in its Revenue Cycle processes and systems in our 2016 – 2019 strategic plan and has been systematically working to improve training and technologies to enhance our revenue capture since that time.

We continue to train staff and physicians on clinical documentation and coding. We have implemented better, more frequent and structured training for both quality and quantity of work completed. We administer discipline when standards are not met. We continue to actively recruit to fill vacant positions and we have augmented in-house staff with the services of a firm experienced in hospital coding and billing.

Revenue Cycle metrics and ref	flects continued pro	gress.		
Metric	Average FYTD 2018	Aug-18	Sep-18	Benchmark

110

8.0

29%

93

6.9

23%

94

7.0

18%

45.85 - 54.90*

NA

NA

While we continue to strive to improve our performance, the below table identifies key Revenue Cycle metrics and reflects continued progress.

Kindly let me know if I can provide further clarification	Kindly let	me know i	f I can p	rovide fur	ther clarification.
---	------------	-----------	-----------	------------	---------------------

Average Days in Accounts

Receivable (lower is better)

Discharged Not Finally Billed

Percentage (lower is better)

Days (lower is better)

Claims Initial Denials

Sincerely,

ns.

John Jay Shannon, MD Chief Executive Officer