COOK COUNTY HEALTH

Prepared Remarks
Dr. Jay Shannon, CEO
July 25, 2019

Good afternoon and thank you for the opportunity to come before you today. I will make some brief opening remarks to ensure that the County Board, the media and the general public are aware of our position on the report issued by the Office of the Inspector General (OIIG) on June 21st.

We are working through our formal response to the report and will submit that accordingly. Yesterday, the County Board received answers to questions they submitted. But for today, I will say that we continue to disagree with both the premise and the conclusion that the health system had $701M in outstanding bills at the end of 2018. And for the benefit of the new members of the county board who have not gone through a budget process yet, I hope that you will indulge me to walk through some facts.

The finances of Cook County Health are stable. In fact, last year, our net position improved to a positive $25M. This could not happen if we had $701M in unpaid bills.

As you know, our local tax allocation has decreased by more than 75% since 2009. At the same time that allocation has decreased, we have experienced the same rising expenses as other healthcare organizations-in pharmaceuticals, equipment, technology, labor costs and more. And yet we remain committed to our historical mission to care for all county residents who need our services regardless of income, immigration or insurance status. These realities demanded strategies that would increase patient revenues, which meant we needed to serve more insured patients.

We started CountyCare in 2013 at a time when our local tax allocation was more than $250M. The Affordable Care Act is what allowed the expansion of Medicaid to previously ineligible adults. Ultimately, it helped thousands of our previously uninsured patients to obtain coverage and remain in our care. A portion of the reimbursements tied to CountyCare capitation has helped us absorb the rising cost of operating this health system. From labor costs to charity care to pharmaceuticals and equipment, our expenses rise every year. And every year, we have generated the revenue to cover those costs without any additional taxpayer support.

We are competing with private institutions that have tens and hundreds of millions of dollars more than we do and we are remaining true to our mission.

To survive required new strategies that were admittedly foreign to the organization. I can say with nearly 100% certainty, that CountyCare has allowed this organization to stay true to its historical mission and that had we not built it and grown it, tens of thousands of patients would have likely lost care. It is a very real possibility that this health system would not exist today without CountyCare OR a major infusion of hundreds of millions of dollars annually from the taxpayers.

If we want Cook County Health to be a continued resource for vulnerable populations, then we need to generate the revenue to pay for it. There is no way to provide charity care at the rate we are providing it without increasing revenues.

With specific regard to the finances of Cook County Health:

The health plan is a budgetary unit within Cook County Health - not unlike Stroger and Provident hospitals or our ambulatory services. All of the revenues and expenses hit the health system's bottom line. The health system follows Generally Accepted Accounting Principles ("GAAP"), and adheres to the rules in the state contract and the rules and regulations set forth by the Centers for Medicare and Medicaid Services. The health system's books are audited annually as part of the County's external audit. The health system is contributing more than $30M annually to the pension fund and is paying the debt service on new equipment and new facilities.

The health system has made monumental strides in recent years in building the infrastructure to support the state's Medicaid managed care strategy as evidenced by a substantial increase in charges every year. In 2018, CCH generated nearly $1.7B in charges, up $400M from 2013. As you know from previous conversations, no hospital receives the full value of charges but these higher charges indicate two things – improved coding and increased clinical activity.

I tell employees every two weeks at orientation that unless they work for public health or correctional health, *they* are responsible for generating the revenue to cover their salaries, their benefits, improvements and upgrades throughout the system as well as to help offset the cost of charity care. This board challenged us to stand on our own two feet and every year, we are moving closer to that reality.

The health plan is generating more revenue than expenses and has contributed more than $1 billion to the health system's budget since 2013.

The health plan is processing on average 400,000 claims every month. That's nearly 5 million claims every year. Paying claims in a timely fashion is a requirement of our state contract but that process requires many stars to align – some outside our control. The whole process starts with the timely submission of a clean claim. Providers are allowed to submit a claim within 180 days of service-that is a Medicaid rule, not a CountyCare rule. That's six months and that is just the start of the process. We can process a clean claim very quickly but can only pay a clean claim if there is sufficient cash flow. While state payments to CountyCare have gotten much more timely under the new administration, lags do continue and payments can be delayed. But we cannot pay a claim that does not meet Medicaid requirements and cannot pay a claim if there is insufficient cash flow. This is where denials come into play. If a claim is submitted on the 180th day and then that claim is denied because it was improperly coded, the denial process can take months to go through. This is one way you might carry obligations over to a new fiscal year, and why you hire an actuary to estimate your potential liabilities. And while we are confident and grateful that Medicaid expansion and CountyCare have stabilized many safety nets, including us, we are required to follow the rules and can only pay clean claims. All of this said, it is important to point out that according to the state, CountyCare has the fewest provider complaints per 1,000 members of all the Medicaid plans.

We completely understand that running a Medicaid health plan is a new line of business for the county and acknowledge that it is not without risk. But those who were here in 2013 understood that it was the clearest path to ensure that the health system could remain true to its historic mission to care for all without turning to local taxpayers for more funding. That path has been immensely successful and has allowed this body to redirect billions of dollars in local taxpayer funds to other County purposes.

As a subunit of county government, we discuss CountyCare financials, membership, quality and operations in the Cook County Health Managed Care Committee, Finance Committee and full board-all public meetings, with detailed reports posted online the day they are presented. We submit monthly reports to this board with

regard to membership, financials, operations and claims payments every month. Since the inception of the health plan, and at the request of the health system board, we have modified the detail and the structure of those reports to enhance clarity and transparency. The health system CFO answers questions every month about revenues and expenses at the health system and within the health plan. We brief our board and this board as often as requested. Despite these efforts, there are assertions that we have not been transparent. I am giving each of you my commitment that if more information is needed, we will be happy to provide it.

What has transpired over the course of these last few weeks is unfortunate. The reputation of the health system and the health plan as well as the integrity of the professionals we are fortunate to have leading the system have been questioned – something that may give insured patients pause as they choose where to get their care, or give providers pause as they contemplate participating in the CountyCare network.

This health system and its mission are far bigger than any of us which is why our board has hired a third party to take a look at many of the questions raised over the past few weeks. We have worked closely with the County CFO in developing the scope of work that I believe will result in a deeper, shared understanding of how a publicly-owned and provider-led managed care plan operates and restore any trust in our team that has been questioned. I am pleased to report that we have engaged Deloitte to conduct this analysis. As they are just getting started and pursuant to the ordinance, we will formally request an extension for our response to the OIIG report. We will submit our formal response which will include this third party analysis as soon as possible. In the meantime, my team will focus on our daily roles supporting the most critical public health care safety net in the region.

In closing, I want to assure you that we are operating CountyCare and the entire health system in a fiscally responsible manner and we are developing and implementing strategies that will allow us to generate the revenue needed to protect our mission.

At this time, I would like to introduce the members of our team who are on the dais today. From the Cook County Health Board of Directors, we have our chair Hill Hammock, our Finance Committee chair Bob Reiter and our Audit and Compliance Committee chair Mike Koetting. Also with us today are James Kiamos, CountyCare CEO and Aaron Galeener who is the Director of Finance for CountyCare.