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June 21, 2019

Dr. John Jay Shannon
Chief Executive Officer
Cook County Health
1950 W. Polk St., Suite 9816
Chicago, Illinois 60612

Re: CountyCare Healthcare Expenses (IIG18-0100)

Dear Dr. Shannon:

This letter is written in accordance with the Code of Ordinances, Cook County, Illinois ch.2, art. IV, sec. 2-289(c)(2) (2007) (the "Ordinance") in connection with a review of CountyCare's healthcare expenses. In accordance with the Ordinance, this statement is made to apprise you of the completion and results of this review.

Background

Cook County Health ("CCH") is the second largest public healthcare system in the nation. CCH serves as a safety net healthcare provider for residents in Chicago and suburban Cook County. CCH also provides healthcare services to numerous insured patients. In 2008, CCH became an independent entity and no longer subject to the operational control of Cook County government. Additionally, Cook County government created the CCH Board of Directors (the "CCH Board") and transferred independent oversight of CCH's operations to the CCH Board. The CCH Board's oversight responsibilities include selecting CCH's senior management and monitoring their performance. Although CCH is an independent entity separate from Cook County government, CCH continues to receive a substantial amount of funding from Cook County government.

CCH has over 6,000 employees and has a $2.7 billion budget, which comprises nearly half of Cook County government's entire budget. As for operations, CCH consists of two hospitals (John H. Stroger, Jr. Hospital and Provident Hospital), a network of more than a dozen community health centers, the Ruth M. Rothstein CORE Center, the Cook County Department of Public Health, Cermak Health Services and CountyCare Health Plan. CountyCare is the primary focus of this review.

CountyCare is a healthcare insurance provider and was created pursuant to the Medicaid expansion initiative commenced under the Affordable Care Act (2009). CountyCare functions very similar to other large insurance companies such as BlueCross/BlueShield and

Aetna. The primary difference is that CountyCare is a Medicaid managed healthcare plan that receives "capitation" revenue ("per member, per month" or "PMPM") from the State of Illinois. CountyCare receives PMPM on a monthly basis for each person enrolled ("Member") in CountyCare. CountyCare has a healthcare network of approximately 4,500 primary care providers, 15,000 specialists, 50 hospitals, and 335,000 Members.[1] Currently, 15% of CountyCare Members obtain their healthcare from CCH and 85% seek care from external healthcare providers.

In connection with financial reporting, CCH produces its own audited financial reports on an annual basis ("CCH Financials"). CCH Financials contain the financial performance for each individual operating unit (e.g., Stroger, Provident, CountyCare, etc.) and are combined to represent CCH's total numbers. The total numbers are referred to as the "consolidated numbers" for CCH and are shown in the Cook County Combined Annual Financial Report ("CAFR"). The CAFR contains financials for CCH, the offices under the President of the Cook County Board of Commissioners, Cook County separately elected officials, and state offices that receive funding from Cook County government.

This review was initiated after receiving information during the course of our review of CCH bad debt expense and claim denials.[2] There, certain senior officials disclosed to us that CountyCare generates a substantial amount of unpaid healthcare expenses and does not have the wherewithal to satisfy those financial obligations during each fiscal period. It was also alleged that Stroger Hospital generates millions in losses due to unpaid healthcare expenses from CountyCare. We commenced this review to evaluate the assertions concerning CountyCare's substantial unpaid healthcare expenses.

OIIG Review

During this review, we interviewed six CCH senior officials, a CCH Board member, two CountyCare senior officials, two CountyCare employees, two Bureau of Finance senior officials, three external auditors, two third-party administrator senior employees, and a State of Illinois employee. Most CCH employees and vendors were professional, knowledgeable and cooperative during our interviews and all other interactions.

Additionally, the significant and relevant documents we reviewed were CCH Financials from 2013-2018, CAFRs from 2013-2018, accounts receivable transaction summaries from 2013-2018, third-party administrator outstanding claims, CCH and CountyCare's Memorandum of Understanding, Milliman Client Reports (Actuaries), Bureau of Finance Revenue Reports presented to the Board of Commissioners, and CCH Monthly Reports to the Board of Commissioners. In most cases, CCH, CountyCare, and County vendors were responsive to our document requests in a timely fashion.

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[1] Data is current to September 1, 2018.

[2] *See OIIG Public Statement IIG17-0421* (March 22, 2018) (Supplement, May 18, 2018) .

Our review identified key managerial decisions and financial policies associated with large volumes of unpaid healthcare expenses. We have highlighted the primary concerns related to the growing unpaid debt:

1. CountyCare's "due from state" tracks delayed payments or backlogs owed to CountyCare. The comparatively small amounts the State tends to owe CountyCare at years-end is dwarfed by the substantial amounts of Claims Payable outstanding at the end of each year. Essentially, the PMPM due from the State in 2018 ($14 million) can only pay 2% of the outstanding liabilities ($701 million) for the 2018 fiscal year-end. Even when excluding the amount internally owed to CCH ($199 million), CountyCare owes external healthcare creditors $502 million. Most of the unpaid debt is owed to vendors because 85% of CountyCare Members obtain their healthcare from external providers.

2. The established trend demonstrates that CountyCare does not generate enough revenue to pay all the outstanding healthcare expenses each fiscal year-end. CCH has developed a practice of using subsequent period budgetary funds to pay prior period bills. In effect, CountyCare is forced to pay substantial prior period and new period healthcare expenses during each fiscal period. Consequently, CountyCare's unpaid healthcare expenses are steadily growing and could become too large to pay without an extraordinary contribution from another funding source in the future.

3. CCH management fails to disclose to the CCH Board and Cook County Board of Commissioners important terms associated with related-party transactions that result in significant financial impacts between CCH and CountyCare. For example, there is a Memorandum of Understanding (MOU) between CCH and CountyCare with key provisions that shift losses between the two related entities. These methods and associated outcomes set forth in CCH Financials are not fully disclosed and explained to the CCH Board and Cook County Board of Commissioners.

4. In 2018, CCH senior officials amended the MOU between CCH and CountyCare to retroactively change reimbursement rates for 2017 due to a state imposed revenue reduction. This retroactive change had a significant negative effect on Stroger Hospital and presented CountyCare as more profitable than it would have been without the change in reimbursement rates from CountyCare to CCH. These events were not fully and clearly disclosed to the CCH Board and Cook County Board of Commissioners.

5. Despite the existence of the MOU, CCH routinely changes revenue and expense figures between CCH's operating units (e.g., Stroger, CountyCare, etc.) to reach desired financial goals for CountyCare and Stroger Hospital in CCH's monthly and annual financial reports. As a result, these practices make it difficult for the CCH Board and Cook County Board of Commissioners to have a sound baseline to evaluate the performance of the individual operating units that make-up CCH.

Budget vs. CCH Financials

CountyCare generated revenues of $1.8 billion and reported a net gain of $3.5 million for fiscal year 2018.[3] Additionally, CountyCare had $14 million due from the state and $701 million in unpaid healthcare claims at the fiscal year-end. CCH Financials are prepared on an accrual basis of accounting pursuant to *Generally Accepted Accounting Principles* ("GAAP"). As such, CCH recognizes revenues when earned and expenses when incurred for the CCH Financials.

There is an important distinction between the County's budget and CCH Financials that should be examined for purposes of this review. CCH has a balanced budget; however, the budget does not recognize unpaid liabilities that are set forth in the CCH Financials.[4] Our review reveals that CountyCare has incurred an estimated $701 million in unpaid healthcare liabilities ending in fiscal year 2018. There is only $14 million due from the State of Illinois to pay for those unpaid healthcare liabilities.[5] The table below shows the year-end balances for CountyCare's accrued revenue (due from state) and CountyCare's unpaid healthcare claims for the past six years.

Year	Due from State	Claims Payable
2013	$49,612,218	$48,156,132
2014	$13,601,144	$101,552,404
2015	$51,750,784	$188,664,189
2016	$45,786,270	$397,091,728
2017	$40,081,223	$458,422,263
2018	$13,805,400	$700,787,380

During this review, we interviewed representatives from CCH, the Cook County Bureau of Finance, the CCH Board and CCH's external auditors and presented the financial figures shown in the chart above seeking their insights into the trend of growing claims payable. Below are statements from the interviews.

CHH Senior Officials

The CountyCare Chief Executive Officer (CEO) stated, "If I had my way, I would trim the [healthcare provider] network because it is too expansive." Another CCH senior official said "after receiving $1.1 billion in PMPM there is no money left and a half billion dollars in

[3] These figures are derived from 2018 CCH Financials released on May 31, 2019. *See* Attachment A.
[4] As an analogy, an individual's bank account shows income from wages and disbursements for expenses. The bank account, however, fails to show the outstanding credit card balance that may have accumulated expenses for many years. In order to truly assess the individual's financial condition, the bank account and credit card statement outstanding should be reviewed together. *See* Attachment B.
[5] Although the state owes CountyCare $14 million, CountyCare owes the state $26 million. When netted together, CountyCare owes the state $12 million. *See* Attachment C.

claims payable on the books. It is only growing. CCH and CountyCare must use fiscal year 2019 revenue to pay fiscal year 2018 bills."

The CCH CEO explained that "this is the first time these numbers have been presented to me this way, but they seem high. I'll need to talk to my financial team about them." He said that if the debt load was unsustainable, the state would not allow them (CCH) to continue this way. He also said, "this is implausible, the $700 million [claims payable].[6] $500 million would be high, very high." The CEO also stated that these figures are representative of a point in time and are different during the year. Additionally, he explained that we must consider that CountyCare experiences PMPM backlogs from the state. We explained to the CEO that "due from the state" shown in the chart tracks PMPM backlogs from the state and these funds are insufficient to pay Claims Payable. The CEO answered, "I can't speak on it because I don't know where the numbers come from."

During an interview with the CCH Deputy Chief Executive Officer in February 2019, the OIIG inquired about the reasons for the substantial unpaid claims. The CCH Deputy CEO believed $700 million in unpaid claims for CountyCare was an inaccurate figure. He said unpaid claims should be closer to the figure in 2017 which was $458 million. Furthermore, he believed $458 would be the final figure at the conclusion of the audit for the 2018 CCH Financials. Regarding the previous years, the Deputy CEO explained that CountyCare experienced both an increase in CountyCare Members and a delay in PMPM payments from the state. Contrary to the CCH Deputy CEO's belief, the final audited 2018 CCH Financials did reveal that unpaid healthcare claims were $701 million at year-end.

We asked the CCH Chief Financial Officer (CFO) to explain why CCH has over $300 million in available cash in its bank account as shown in the 2017 CCH Financials, although CountyCare failed to pay down its Claims Payable. Moreover, there are vendors who are complaining about the failure to receive timely payment from CCH. The CFO said he does not have to pay vendors and creditors immediately. That is, he wants to collect revenue as soon as possible and pay bills as late as possible. He also said, "Downtown [Cook County government officials] would kill me if I paid all my bills at once. We have the same bank account." He indicated that CCH leaves cash in the bank because the Comptroller needs to maintain a certain cash balance to meet the County's debt covenants.

Another CCH senior official explained that the $300 million in CCH's bank account is for the entire healthcare system (Stroger, Provident, CountyCare, etc.) and not exclusively for CountyCare's use. The CCH Deputy CEO confirmed this statement.

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[6] These interviews were conducted while the 2018 CCH Financial audit was ongoing and the unpaid healthcare expenses were preliminary. Although the OIIG interviewed the CCH CEO before the final 2018 CCH Financials were released, the final numbers were almost exactly the same as the preliminary numbers.

External Auditors

When asked about CountyCare's substantial unpaid claims, the audit partner stated that his process is focused on cash flow and CCH's ability to pay claims within the statutory 90-day rule and on accurate accounting and legal compliance during the audits of CCH. The audit partner explained that there is the assumption that County government will make contributions (subsidies) to keep CCH afloat in the event of a liquidity problem.

Cook County Bureau of Finance

The Cook County CFO stated that, although he is concerned about the high debt load ($701 million), the healthcare system is not at a breaking point. However, he acknowledged that, if CCH and CountyCare did not improve, it could develop into such a scenario. The County CFO explained that the rising debt is a trend to be monitored. Furthermore, he stated that the high Claims Payable figures are not just the fault of CCH, rather they can be partially attributed to the state. He explained that the state failed to pay CCH and CountyCare when the state did not have a budget in the previous years. The CFO said that 90-120 days is the regular payment cycle and CountyCare is still working within that payment cycle.

We also interviewed the Cook County Comptroller and presented the 2017 CCH Financials that showed CCH had more than $450 million in outstanding healthcare liabilities. The Comptroller explained that the state is frequently late in disbursing PMPM to CountyCare. We inquired as to why there were substantial unpaid claims when a significant portion of the PMPM due from the state had been reported as received in the 2017 CCH Financials. The Comptroller said, "You are looking for the same answers as everyone else and asking how CCH is going to pay those liabilities."

We have received information from various sources indicating that many vendors and government agencies experienced delayed payments when the state did not have a budget. Notwithstanding the historical circumstances involving delayed payments and backlogs owed to CountyCare, a developing trend of decreased backlog and increased Claims Payable is remarkable. Currently, the comparatively small amount the state owes to CountyCare at years-end is dwarfed by the substantial amount of Claims Payable outstanding. The PMPM due from the State ($14 million) represents 2% of the outstanding claim liabilities ($701 million) for 2018 fiscal year-end.

Chairman of the CCH Board of Directors

The Chairman said the days outstanding for the Claims Payable figures are an important consideration, and CCH presents a monthly report to the Board that tracks unpaid claims for CountyCare. He also said there was an increase in CountyCare's Membership that would obviously cause an increase in Claims Payable. CCH senior officials could not provide the OIIG with an aging report that tracks unpaid claims. Instead, we were provided a report that states the length of time it takes CountyCare to pay a claim that is deemed ready for payment.

This report does not track all outstanding claims that may still be going through the review process with the third-party administrator.

Further, the Chairman stated that the healthcare providers are not complaining about a failure to receive payment. We informed the Chairman that there have been numerous complaints from vendors alleging slow and non-payments.[7] In fact, there are healthcare providers who have refused to provide healthcare to CountyCare members due to the lack of payments. Additionally, we have learned through email reviews that some contractors have placed CCH's accounts on hold for the lack of payment resulting in a shortage of pacemakers and anesthesia for surgeries.

"New Money to Pay Old Bills"

A CCH senior official has stated that CountyCare runs out of money each fiscal year which requires CountyCare to use money for the upcoming fiscal period to pay old bills. Upon a review of the general ledger, we identified a pattern that substantiated the CCH senior official's claim. This pattern potentially signifies that CountyCare does not possess sufficient financial resources or capacity to satisfy the financial obligations incurred during the same budget cycles. Below is a table that shows unpaid bills for six fiscal years-end and substantial payments made in the following budgetary period.

Year	Fiscal Year End Claims Payable	Payment next Fiscal Year
2013	$48,156,132	$5,609,708
2014	$101,552,404	-
2015	$188,664,189	$221,792,999
2016	$397,091,728	$242,454,726
2017	$458,422,263	$219,984,524
2018	$700,787,380	$192,700,774

We inquired of representatives from CCH, Cook County Bureau of Finance, the CCH Board, and CCH's external auditors to explain the reasons underlying CCH's reoccurring practice of paying prior period expenses with new period revenue.

CCH Senior Officials

A senior CCH official stated that CountyCare "uses new money to pay old bills." The senior CCH official explained that after receiving $1.1 billion in PMPM there is no money left and a half billion dollars in Claims Payable on the books. The senior official said unpaid liabilities are only growing and CCH must use fiscal year 2019 revenue to pay fiscal year 2018

[7] Subsequent to the interview, WBEZ published an article on May 16, 2019 stating that a community hospital is experiencing severe financial troubles and operational problems due to unpaid claims. Further, this hospital said CountyCare owes them $4 million which is more than any other healthcare plan. During our review, we received the same information from a high-ranking official at that community hospital.

bills. Furthermore, the senior official stated that it has been happening each year and no entity could continue carrying growing substantial liabilities year to year. The CCH senior official said, "[CCH] keeps kicking the can down the road."

Cook County Bureau of Finance

The Cook County CFO explained that the Claims Payable figure includes claims that have already been received from the vendors and those claims CountyCare expects to be received in the future ("IBNR").[8] Moreover, CCH may hold invoices because CCH is waiting for a PMPM payment from the State. The CFO said his understanding of CountyCare's inability to pay its healthcare claims is because the state has not yet paid CountyCare. We have received information suggesting that money yet to be received from the state is not necessarily the reason. The 2018 CCH Financials show that CountyCare generated $1.8 billion in revenue. We confirmed with the Comptroller's Office that CountyCare has received $1.8 billion from the state. CCH has previously consumed its entire fiscal year budgeted revenue within the first quarter due to prior period bills.

The Comptroller said "in December and January, CCH receives an infusion of money and [County officials] are happy, but they do not realize it is applied to prior period bills." He said that in November 2018, budgeted expenses and actual expenses were completely in line. There were no deficits or surpluses. Nonetheless, as stated previously, the 2018 CCH Financials identify $701 million in Claims Payable with only $14 million due from the state. Importantly, budgets do not include unpaid healthcare liabilities as do financial reports pursuant to GAAP.

Member of the CCH Board of Directors

The Chairman explained that CountyCare receives substantial PMPM payments late in the fiscal period with no time to apply these payments to outstanding Claims Payable. Therefore, CountyCare makes substantial payments on outstanding claims in the subsequent budgetary period.

This office reviewed information maintained by the Comptroller's Office that tracks PMPM payments received from the state. The report documented the state remitting over $269 million in November 2018 of the $1.8 billion paid in PMPM to CountyCare.[9] According to the 2018 CCH Financials, CCH consolidated cash balance is $372 million at year-end. This means that after CountyCare applies $269 million to outstanding healthcare claims ($701 million), the entire CCH healthcare system has only $102 million ($372 million-$269 million) for its operations and CountyCare still has $432 million ($701 million-$269 million) remaining in outstanding healthcare claims.

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[8] IBNR is an acronym for invoiced but not received. IBNR is an estimate of the vendors that have provided healthcare services to CountyCare Members, but CountyCare has not received the bills for those claims. CountyCare tracks these pending liabilities.

[9] *See* Attachment D.

CountyCare Shifts Losses to CCH

Certain senior CCH officials stated that Stroger Hospital ("Stroger") experiences substantial losses primarily due to the low reimbursement rate afforded by CountyCare for healthcare services provided to CountyCare Members.[10] Accordingly, we reviewed CCH Financials and noted that Stroger incurred net losses of approximately $122 million for fiscal year 2017.

The MOU that CountyCare has with CCH establishes the reimbursement rate for healthcare services Stroger Hospital provides to CountyCare Members. Importantly, the MOU was amended in February 2018, and retroactively reduced the reimbursement rate to Stroger Hospital from 75% to 26% for the 2017 fiscal period.[11] The OIIG subsequently conducted the following interviews to ascertain the reasons for the retroactive change of the reimbursement rate.

CHH Senior Officials

We asked the Director of Finance for CountyCare to explain the methodology used for retroactively reducing the reimbursement rate in the MOU from 75% to 26% for CCH in 2018 for the 2017 fiscal period. He explained that he, along with other senior officials, determine how the financials should appear for the two different entities (CountyCare and Stroger Hospital), including which one will show gains and losses in financial reports. However, the final figures were determined by the (former) CCH Deputy CEO.

The Director of Finance also explained that CountyCare reduced the reimbursement rate to 26% for Stroger when the State of Illinois reduced PMPM for CountyCare. This reduction was referred to as a "clawback." Senior officials determined that CCH should cover the burden associated with the clawback rather than transfer any of the costs to other healthcare providers within the CountyCare network.

We asked the CCH CFO if reducing the reimbursement rate from 75% to 26% would have shifted expenses from CountyCare to CCH which allowed CountyCare to appear more profitable. The CCH CFO used an analogy to explain. He said that the CAFR views the County as a family and one would not ask why one child performed better than the other. Rather, the CCH CFO said he is concerned with the family as a whole.

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[10] In an IIG17-0421 Supplemental Report (May 18, 2018), it was documented that CCH can expect to be reimbursed approximately 62-65% for claims submitted to healthcare insurers other than to CountyCare.

[11] We reviewed the accounts receivable transaction reports to determine whether CountyCare actually reimbursed CCH at the rates stipulated in the MOU. CountyCare does not follow the terms set forth in the MOU for reimbursing CCH. Additionally, the OIIG learned from the third-party administrator that CountyCare denied CCH's claims totaling $62 million in 2017 and $50 million in 2018. *See* Attachment E.

The Deputy CEO explained that CountyCare's reimbursement rate to CCH is a function of different considerations. The primary considerations are the state Medical Loss Ratio ("MLR")[12] and the federal government disproportionate share hospital limitation ("DSH").[13] If CountyCare reimburses CCH too much, the state MLR will be satisfied, but there is a risk that CCH would owe the federal government a DSH refund. The CCH Deputy Chief Officer said "giving the system [CCH] a high payment could create losses to our overall organization by virtue of giving back disproportionate share." Furthermore, he explained, "We've come to the end of the year and we've said okay, now based on all the factors we have, this is what we'll go back and pay ourselves."

The CCH CEO stated that management can determine what "they can pay themselves" pursuant to Medicaid rules. That is, CCH senior officials have the ability to pay any provider within a certain range. The OIIG asked the CCH CEO the reasons for deciding that CCH should absorb the entire loss from the state clawback. He replied that CountyCare could have taken the loss, but at the end of the day it all washes out because CCH's consolidated numbers would remain the same.

External Auditors

The audit partner was unaware of the retroactive change in the reimbursement rate set forth in the MOU. He stated that it is difficult to opine on related-party transactions for an audit because there is substantial flexibility in such areas. Moreover, the audit partner focuses on CCH's consolidated number and not the individual departments vis-à-vis CountyCare and Stroger Hospital. The audit partner explained "No assurance [by the auditors] is made to the sub-columns in the financials [Stroger, Provident, CountyCare, etc.], however, a risk assessment is made." The audit partner explained further that if the scope of the audit included the sub-column financials, including the consolidated figures, the audit cycle would become overburdensome so the auditors rely on the accuracy of internal reporting in the sub-columns. The audit partner also said that any intentional misstatements in the CCH Financials would cause him to notify senior officials and the audit committee whether it is a material or non-material misstatement.

Cook County Bureau of Finance

The County CFO reiterated that the consolidated numbers should be the main focus for his purposes. The OIIG investigators stated that the numbers from the other departments comprise the "consolidated numbers." As such, these department numbers are important to manage operations, identify any problems, and plan for improvements. The CFO agreed that strategic planning is important and there could be a problem with planning when the numbers

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[12] The MLR requires that CountyCare dedicate at least 85% of the PMPM to patient care. The remaining 15% of PMPM can be used for administrative costs. If CountyCare spends less than 85% on patient care, the State of Illinois can recoup revenue from CountyCare for the differential.

[13] Federal law requires that state Medicaid programs make Disproportionate Share Hospital (DSH) payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals.

are not accurate or changed to meet a financial goal for the operating units (Stroger Hospital v. CountyCare).

Chairman of the CCH Board of Directors

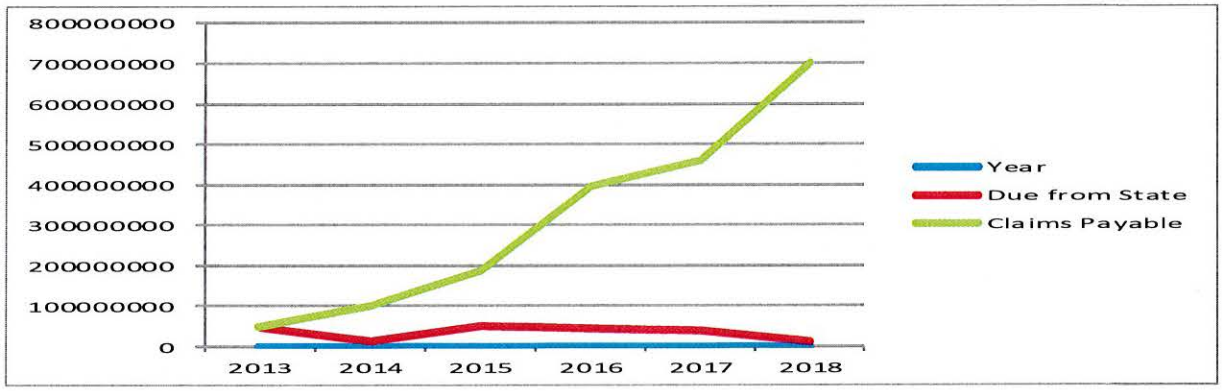
The Chairman said he is not concerned about CCH managing or changing financial figures. He stated there are different people who place boundaries on what can be done by CCH senior officials in connection with controlling the financial results for the separate entities. He said external auditors, internal auditors, and state auditors impose limitations on what can be changed and controlled by management. The OIIG asked whether the CCH Board knew or should have known about the method that CCH senior management utilized to absorb the $140 million state clawback. The Chairman stated that this was a managerial decision. Additionally, he stated that if it had been presented to the CCH Board it would have involved extensive discussions by the CCH Board, though in the end the outcome would had been the same.

County Government Subsidy v. Unpaid Bills

From 2013 through 2018, taxpayer contributions (County subsidies) have decreased, but CountyCare's unpaid healthcare expenses have substantially increased. Although taxpayer contributions have assisted in balancing the cash budget, they have only partially and indirectly offset actual losses identified in CCH Financials pursuant to GAAP. Although one could argue no direct correlation, it is indisputable that a trend has developed as set forth below. Senior officials from CCH, Cook County Bureau of Finance, the CCH Board, and CCH's external auditors have stated that Claims Payable is due, at least in part, to the backlogs created by delays in payment from the state and timing issues. To be sure, however, it is also indisputable that the PMPM due from the state has been insufficient to cover Claims Payable at fiscal years-end and CountyCare is never able to "catch up" on outstanding Claims Payable. The Claims Payable figures can be seen as a financial shortfall.

Year	Taxpayer Contribution	Claims Payable
2013	$251,500,000	$48,156,132
2014	$175,000,000	$101,552,404
2015	$164,000,000	$188,664,189
2016	$121,200,000	$397,091,728
2017	$106,400,000	$458,422,263
2018	$101,900,000	$700,787,380

Below is a depiction of the gap between "due from state" and outstanding "Claims Payable." Claims Payable have reached $701 million while CountyCare is due only $14 million from the state at the end of fiscal year 2018. As shown in this chart, the difference has been steadily growing each year.



OIIG Findings and Recommendations

These matters are significant because CountyCare has accumulated $701 million[14] in unpaid healthcare liabilities as of November 30, 2018. This figure has increased by $242 million or 52.9% from fiscal year 2017. As of November 30, 2018, the state owes CCH just $14 million, though CCH owes the state $26 million. These developing financial circumstances are further aggravated by the fact that CCH has experienced interruptions in healthcare services due to its inability to pay vendors.

In light of the facts gathered, we have developed the following recommendations to assist in improving financial and operational transparency and accountability related to CountyCare's unpaid healthcare expenses.[15]

1. CountyCare's cash balance, capitation revenue due from the state, and outstanding Claims Payable should be clearly stated in comparison form in a report so that the CCH Board and Cook County Board of Commissioners can timely monitor these financial conditions on a regular basis.

2. The CCH Board of Directors should mandate an in-depth analysis of the unpaid healthcare expenses and create a plan to reverse the established trend. CCH should also provide timely and accurate Claims Payable aging reports. These expenses are steadily growing and could become too voluminous to manage without an extraordinary contribution from another funding source in the future. Additionally, to the extent possible, future PMPM revenues should be matched with future healthcare expenses.

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[14] Of this amount, CountyCare owes approximately $200 million to Stroger Hospital.

[15] We do not dismiss the reasoning provided by several officials interviewed that increased Claims Payable, at some juncture, was the result of a back log from the state in capitation revenue or that an increase in CountyCare membership naturally triggered increased Claims Payable. We do, however, disagree that these factors account for the established trend of outstanding Claims Payable liabilities. The state back log now appears to be of historical significance. Moreover, if new capitation revenue that is triggered by an increase in CountyCare membership cannot keep up with Claims Payable, the core problem will only be compounded at a faster pace. This is our concern.

3. CCH should be required to provide more transparency in connection with related party transactions. There should be disclosures that highlight the key terms in the MOU between CCH and CountyCare such as the reimbursement rate and any adjustments. The reimbursement rate provides critical information for the CCH Board of Directors and County Board of Commissioners when making decisions related to budgetary and policy matters. These matters include understanding what factors are driving CCH losses and understanding the trend reflecting increased Claims Payable liabilities.

4. The CCH Financials should reflect the actual figures generated in each respective department. Managerial discretion should be eliminated when determining which operating units should encounter a gain or loss. This is separate and apart from the adjustments in reimbursement rates documented in the MOU between CCH and CountyCare. When senior management subjectively adjusts revenues and expenses, the CCH Board and Cook County Board of Commissioners are not provided an opportunity to develop a factually sound assessment of CCH's operations for planning purposes. While the consolidated numbers reflected in the CAFR remain a major focus, the financial data supporting the consolidated numbers tells an equally important story of the condition of the critical operating units within CCH and are relevant for the determination of policy.

5. As outlined above, 15% of CountyCare Members obtain their healthcare from CCH and 85% seek care from external healthcare providers. This results in the vast majority of CountyCare's revenues from the State of Illinois going directly to external healthcare providers. We received statements that CountyCare could retain more patients if its primary care physicians made internal referrals and encouraged their patients to use services within CCH. Perhaps, CCH senior management could advise department heads to coordinate interdepartmental presentations with a goal of increasing internal referrals. To be sure, however, this is just one glaring possibility to assist in changing the current imbalance between internal and external providers of CountyCare Members. We recognize that other more complex realities exist that also drive this imbalance. CCH should aggressively move toward addressing this issue at every level possible across all departments.

Finally, in accordance with section 2-285(e) of the OIIG Ordinance, we respectfully request notification within 45 days of any action taken in response to these recommendations. We hope this information proves helpful. If you have any questions or would like to discuss these issues further, please do not hesitate to contact me. Thank you for your time and consideration.

Very truly yours,

Patrick M. Blanchard
Inspector General

attch.

Via Electronic Mail Delivery

cc: Honorable Toni Preckwinkle
Honorable Members of the Cook County Board of Commissioners
Mr. M. Hill Hammock, Chairman, Board of Directors, Cook County Health
Cook County Health Members of the Board of Directors
Ms. Lanetta Haynes Turner, Chief of Staff, Office of the President
Ms. Laura Lechowicz Felicione, Special Counsel to the President
Mr. Ammar Rizki, Cook County Chief Financial Officer
Ms. Deborah J. Fortier, Cook County Health, Associate General Counsel
Mr. Ekerete Akpan, Cook County Health, Chief Financial Officer

Cook County Health and Hospitals System of Illinois

Combining Schedule of Revenues, Expenses, and Changes in Net Position of Operating Accounts Information
Year Ended November 30, 2018

	Bureau of Health Services	John H. Stroger, Jr. Hospital	Provident Hospital	Department of Public Health	Cermak Health Services	County Care	Intra-Activity Eliminations	Total
Operating revenues:								
Net patient service revenue - net of bad debt provision of $247,389,767	$ -	$ 597,130,941	$ -	$ -	$ -	$ -	$ -	$ 597,130,941
CountyCare capitation	-	199,227,092	-	-	-	1,822,414,772	(199,227,092)	1,822,414,772
Provident Hospital capitation	-	-	115,406,928	-	-	-	-	115,406,928
Electronic health record incentive program revenue	-	1,558,760	-	-	-	-	-	1,558,760
Other revenue	(983)	11,625,261	358,591	1,940,173	231,836	-	-	14,154,878
Total operating revenues	(983)	809,542,054	115,765,519	1,940,173	231,836	1,822,414,772	(199,227,092)	2,550,666,279
Operating expenses:								
Salaries and wages	36,833,747	461,361,587	33,366,637	8,089,415	59,107,562	2,857,230	-	601,616,178
Employee benefits	6,506,275	73,849,157	5,494,195	1,721,907	9,500,010	705,848	-	97,777,392
Pension expense	-	(3,110)	-	(151)	-	-	-	(3,261)
Supplies	512,439	126,219,912	2,578,289	12,873	9,402,764	774,672	-	139,500,949
Purchased services, rental and other	23,358,135	163,743,110	11,025,133	587,876	8,174,520	62,249,647	-	269,138,421
Foreign claims	2,055,553	-	-	-	-	1,743,182,979	(199,227,092)	1,546,011,440
Insurance	-	30,356,568	1,507,831	-	-	-	-	31,864,399
Depreciation	2,472,074	20,975,269	1,345,721	1,168	86,573	9,110,247	-	33,991,052
Utilities	16,807	11,125,509	1,484,601	64,844	19,378	31,998	-	12,743,137
Services contributed by other County offices	-	33,995,599	2,748,464	-	-	-	-	36,744,063
Total operating expenses	71,755,030	921,623,601	59,550,871	10,477,932	86,290,807	1,818,912,621	(199,227,092)	2,769,383,770
Operating (loss) gain	(71,756,013)	(112,081,547)	56,214,648	(8,537,759)	(86,058,971)	3,502,151	-	(218,717,491)
Nonoperating revenues:								
Property taxes	10,648,567	13,528,266	123,028	179,115	39,387,261	-	-	63,866,237
Sweetened beverage taxes	-	3,455,003	-	-	863,751	-	-	4,318,754
Interest income	-	391,861	3,136	-	-	-	-	394,997
Total nonoperating revenues	10,648,567	17,375,130	126,164	179,115	40,251,012	-	-	68,579,988
(Loss) gain before capital contributions and transfers in	(61,107,446)	(94,706,417)	56,340,812	(8,358,644)	(45,807,959)	3,502,151	-	(150,137,503)
Capital contributions	-	71,204,340	30,233	-	403,970	-	-	71,638,543
Transfers in	-	36,885,415	2,748,464	-	-	-	-	39,633,879
Change in net position	(61,107,446)	13,383,338	59,119,509	(8,358,644)	(45,403,989)	3,502,151	-	(38,865,081)
Net position (deficit):								
Beginning of year	(1,158,950,193)	1,474,789,580	232,041,088	127,757,368	(124,162,716)	(34,955,148)	-	516,519,979
End of year	$ (1,220,057,639)	$ 1,488,172,918	$ 291,160,597	$ 119,398,724	$ (169,566,705)	$ (31,452,997)	$ -	$ 477,654,898

Cook County Health and Hospitals System of Illinois

Combining Statement of Net Position of Operating Accounts Information (Continued)
November 30, 2018

	Bureau of Health Services	John H. Stroger, Jr. Hospital	Provident Hospital	Department of Public Health	Cermak Health Services	County Care	Intra-Activity Eliminations	Total
Liabilities and Net Position (Deficit)								
Current liabilities:								
Due to Cook County Treasurer	$ 1,446,873,412	$ -	$ -	$ -	$ 222,154,641	$ -	$ (1,669,028,053)	$ -
Accounts payable	15,066,514	81,239,527	2,127,533	180,443	1,731,529	21,386,884	-	121,732,430
Accrued salaries, wages and other liabilities	1,919,983	12,356,136	866,583	244,042	1,608,836	346,996	-	17,342,576
Claims payable	-	-	-	-	-	700,787,380	(199,227,092)	501,560,288
Compensated absences	442,810	5,154,341	409,744	100,566	502,381	65,800	-	6,675,642
Unearned revenue	-	15,726,042	-	-	-	-	-	15,726,042
Due to State of Illinois	-	6,993,514	-	-	-	26,413,189	-	33,406,703
Due to other County governmental fund	-	31,455	5,000	7,000	-	-	-	43,455
Interaccount payable (receivable)	(243,285,944)	(623,735,174)	112,984,767	1,629	3,846,754	750,187,968	-	-
Total current liabilities	1,221,016,775	(502,234,159)	116,393,627	533,680	229,844,141	1,499,188,217	(1,868,255,145)	696,487,136
Compensated absences, less current portion	2,509,255	29,207,937	2,321,881	569,871	2,846,827	372,866	-	37,828,637
Property tax objections	2,249,924	2,884,253	81,456	106,141	7,020,102	-	-	12,341,876
Total liabilities	1,225,775,954	(470,141,969)	118,796,964	1,209,692	239,711,070	1,499,561,083	(1,868,255,145)	746,657,649
Net Position (Deficit):								
Net investment in capital assets	4,506,248	476,740,982	18,476,281	-	963,608	27,392,503	-	528,079,622
Unrestricted	(1,224,563,887)	1,011,431,936	272,684,316	119,398,724	(170,530,313)	(58,845,500)	-	(50,424,724)
Total net position (deficit)	$ (1,220,057,639)	$ 1,488,172,918	$ 291,160,597	$ 119,398,724	$ (169,566,705)	$ (31,452,997)	$ -	$ 477,654,898

Attachment B

Cook County Health and Hospitals System of Illinois

Combining Statement of Net Position of Operating Accounts Information
November 30, 2018

	Bureau of Health Services	John H. Stroger, Jr. Hospital	Provident Hospital	Department of Public Health	Cermak Health Services	County Care	Intra-Activity Eliminations	Total
Assets								
Current assets:								
Cash and cash equivalents								
Cash in banks	$ -	$ 5,276,320	$ 123,006	$ -	$ -	$ -	$ -	$ 5,399,326
Cash held by Cook County Treasurer	-	112,948,849	330,866,918	120,019,335	-	1,376,879,711	(1,669,028,053)	271,686,760
Working cash fund	-	95,147,154	-	-	-	-	-	95,147,154
Total cash and cash equivalents	-	213,372,323	330,989,924	120,019,335	-	1,376,879,711	(1,669,028,053)	372,233,240
Property taxes receivable - net:								
Tax levy - current year	931,203	2,456,039	407,400	477,242	68,433,034	-	-	72,704,918
Tax levy - prior year	280,864	435,233	44,151	57,363	(696,489)	-	-	121,122
Total property taxes receivable	1,212,067	2,891,272	451,551	534,605	67,736,545	-	-	72,826,040
Receivables:								
Patient accounts - net of allowances of $262,197,067 in 2018 and $348,978,050 in 2017	-	90,954,446	7,167,933	-	-	-	-	98,122,379
Due from State of Illinois	-	-	-	-	-	13,805,400	-	13,805,400
Capitation receivable	-	201,156,848	49,154,447	-	-	30,472	(199,227,092)	51,114,675
Third-party settlements	-	14,389,778	682,278	-	-	-	-	15,072,056
Other receivables	-	2,897,827	2,059,002	54,476	1,357,873	-	-	6,369,178
Total receivables	-	309,398,899	59,063,660	54,476	1,357,873	13,835,872	(199,227,092)	184,483,688
Refundable deposit	-	2,000,000	-	-	-	-	-	2,000,000
Inventories	-	8,627,473	976,145	-	86,339	-	-	9,689,957
Total current assets	1,212,067	536,289,967	391,481,280	120,608,416	69,180,757	1,390,715,583	(1,868,255,145)	641,232,925
Refundable deposits	-	5,000,000	-	-	-	50,000,000	-	55,000,000
Capital assets, net of accumulated depreciation	4,506,248	449,232,764	17,073,781	-	155,666	27,392,503	-	498,360,962
Capital assets not being depreciated	-	27,508,218	1,402,500	-	807,942	-	-	29,718,660
	4,506,248	476,740,982	18,476,281	-	963,608	27,392,503	-	528,079,622
Total assets	5,718,315	1,018,030,949	409,957,561	120,608,416	70,144,365	1,468,108,086	(1,868,255,145)	1,224,312,547

(Continued)

PMPM from the State **CountyCare** **November 2018 Payments**						**PMPM**
NOV-18	41222.4896.15890.409561.00000.00000	C74911 State Med CountyCare ACA PMPM 10/18 Il Fds	Spreadsheet A 370181 6417070	0.00	(53,297,886.99)	(53,297,886.99)
NOV-18	41222.4896.15890.409561.00000.00000	C74912 IHA HlthCare MCAP Plan by Region ACA P3 11/7 IL	Spreadsheet A 368421 6417186	0.00	(9,598,425.76)	(9,598,425.76)
NOV-18	41222.4896.15890.409561.00000.00000	C74912 IHA HlthCare MCAP Plan by Region FHP P3 11/7 IL	Spreadsheet A 368421 6417186	0.00	(11,670,888.53)	(11,670,888.53)
NOV-18	41222.4896.15890.409561.00000.00000	C74912 IHA HlthCare MCAP Plan by Region ICP P3 11/7 IL	Spreadsheet A 368421 6417186	0.00	(14,672,057.50)	(14,672,057.50)
NOV-18	41222.4896.15890.409561.00000.00000	C74926 State Med CountyCare ACA PMPM 9/18	Spreadsheet A 368792 6486708	0.00	(54,497,308.75)	(54,497,308.75)
NOV-18	41222.4896.15890.409561.00000.00000	C74944 State Med CountyCare ACA PMPM Retro WT11/15	Spreadsheet A 372601 6650916	0.00	(46,183,148.10)	(46,183,148.10)
NOV-18	41222.4896.15890.409561.00000.00000	C75012 State Med PMPM IL Fds M11 WT 11/29-30	Spreadsheet A 373233 6746776	0.00	(44,389,819.09)	(44,389,819.09)
NOV-18	41222.4896.15890.409561.00000.00000	C75013 CountyCare ACA PMPM IGT IL Fds 11/29	Spreadsheet A 375391 6778849	0.00	(108,486,714.92)	(108,486,714.92)
NOV-18	41222.4896.15890.409561.00000.00000	Pm IHA HlthCare MCAP Plan by Region IGT 11/7 P3	Spreadsheet A 368421 6417186	35,941,371.79	0.00	35,941,371.79
NOV-18	41222.4896.15890.409561.00000.00000	State IGT Med Managed Care Pmt 11/20	Spreadsheet A 375390 6778827	23,275,345.61	0.00	23,275,345.61
NOV-18	41222.4896.15890.409561.00000.00000	State IGT Med PMPM M12 11/27	Spreadsheet A 372731 6676297	1,679,916.09	0.00	1,679,916.09
NOV-18	41222.4896.15890.409561.00000.00000	Trfr CountyCare - Prov Access fees IGT Recl DL	Spreadsheet A 373296 6756750	36,045,440.50	0.00	36,045,440.50
NOV-18	41222.4896.15890.409561.00000.00000	Trfr Prov Access fees-CountyCare IGT 11/20	Spreadsheet A 375391 6778849	0.00	(23,275,345.61)	(23,275,345.61)
				96,942,073.99	**(366,071,595.25)**	**(269,129,521.26)**

Attachment D

FIRST AMENDMENT
TO THE
COOK COUNTY HEALTH AND HOSPITALS SYSTEM
COUNTYCARE MEMORANDUM OF UNDERSTANDING

This **First Amendment ("Amendment")** to the **Cook County Health and Hospitals System CountyCare Memorandum of Understanding** is entered into between the County of Cook ("County"), through its **Cook County Health and Hospitals System ("CCHHS")**, and **Cook County Health and Hospitals System (Participating Provider")**, (CCHHS and Participating Provider referred to herein individually as a "Party" or, collectively, as the "Parties").

RECITALS

WHEREAS, on July 1, 2014, the Parties entered into an agreement entitled the "Memorandum of Understanding between CountyCare Health Plan and Cook County Health and Hospitals System" (referred to herein as the "Memorandum of Understanding"); and this amendment effective on December 1, 2017~~6~~ AB

WHEREAS, the Parties desire to amend the Memorandum of Understanding as set forth in this Amendment;

NOW THEREFORE, in consideration of the forgoing recitals, as well as the mutual agreements herein set forth, the adequacy and sufficiency of which is hereby acknowledged, CCHHS and Participating Provider hereby agree as follows:

1. RECITALS

1.1. The foregoing recitals are hereby incorporated into and made a part of this Amendment.

2. AMENDMENT

2.1. The Memorandum of Understanding is hereby amended in the following respects:

2.1.1. Attachment A, entitled "Participating Facility Reimbursement Methodology" shall be deleted in its entirety and replaced by the following amended Attachment A:

Attachment E

Attachment A

Participating Facility Reimbursement Methodology

Inpatient and Outpatient Services. For inpatient and outpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Participating Facility's tax identification number ("TIN"), CCHHS shall pay Participating Facility twenty-six percent (26%) of billed charges for all services, exclusive of Pharmacy services. Pharmacy services shall be reimbursed at seventy-percent (70%) of adjudicated claim cost. CCHHS' obligation to pay Participating Facility pursuant to this Exhibit shall at all times be subject to the terms and conditions set forth in the Agreement, this Exhibit and the Provider Manual.

Inpatient Outlier. Outlier claims shall be reimbursed based upon the State reimbursement methodology.

Additional Provisions:

1. Application of Seventy-Two (72) House Rule. If applicable, payments made to Participating Facility for inpatient services shall include all costs relating to a Covered Person's pre-admission diagnostic testing and procedures, including, but not limited to, laboratory services, pathology services, radiology services, and medical/surgical supplies, occurring within seventy-two (72) hours of an admission.

2. Payment for Professional Services. Payment for those professional Covered Services, including but not limited to services provided by hospital-based physicians, certified nurse anesthetists or other professionals, that are billed on a claim form under Participating Facility's TIN and provider identification number in connection with inpatient Covered Services is included in any payment for such inpatient Covered Services pursuant to this Exhibit. Payment for those professional Covered Services that are billed on a CMS 1500 or its successor form under Participating Facility's TIN and provider identification number in connection with outpatient Covered Services shall be determined pursuant to the Medicaid physician services fee schedule.

3. Coordination for Transplant Services. Participating Facility agrees to coordinate transplant Covered Services and reimbursement for such Covered Services with HMO's designated transplant vendor.

4. Multiple Dates of Service on Single Claim Form. Participating Facility is required to identify each date of service on the Claim Form when submitting claims for multiple dates of service.

5. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

6. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

7. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual.

Definitions:

Allowable Charges means those Participating Facility-billed charges for services that qualify as Covered Services.

OTHER TERMS AND CONDITIONS OF THE AGREEMENT

All other terms, conditions and provisions of the Memorandum of Understanding shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties agree to the above terms and have caused this Amendment to be signed by their duly authorized representatives:

FOR PARTICIPATING ~~PROVIDER~~ PLAN: _____

Signature: [redacted] Date: 2/14/18

Name: [redacted]

Title: [redacted]

FOR COOK COUNTY HEALTH AND HOSPITALS SYSTEM:

[redacted] Date: 2-6-18

for [redacted]

Cook County Health and Hospitals System