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Services LLP

September 4, 2019

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Chief Executive Officer

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Cook County Health and Hospital System of Illinois
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**Re: Assistance with analysis of concerns, findings and recommendations of the Office of Independent Inspector General (the "Assessment") and related matters**

## I. Introduction

### A. Background

Cook County Health and Hospitals System of Illinois ("CCH") received a letter from the Office of the Independent Inspector General ("OIIG") dated June 21, 2019 in connection with a review of CountyCare's healthcare expenses (the "OIIG Letter").[1] The OIIG's stated purpose of the review was to evaluate the assertions purportedly made to the OIIG concerning CountyCare's "substantial unpaid healthcare expenses".[2] The OIIG Letter included five findings and five recommendations, along with a request that the OIIG be notified of any action taken by CCH in response to the recommendations, in accordance with section 2-285(e) of the OIIG Ordinance.[3]

CCH engaged Deloitte Financial Advisory Services LLP ("Deloitte FAS" or "we", or "our") by letter dated July 25, 2019 (the "Engagement Letter") to assist CCH with its performance of the Assessment.

### B. Scope and Approach

In connection with the Assessment, our procedures performed have included: (1) data collection and analysis, (2) informational and fact-finding interviews of personnel with knowledge related to this matter, and (3) an assessment of the OIIG's findings and recommendations articulated in the OIIG Letter, based

[1] OIIG Letter, p. 2.
[2] OIIG Letter, p. 2.
[3] OIIG Letter, p. 13.



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on the results of our analyses and interviews. Refer to **Appendix 1** and **Appendix 2** to this report for lists of information received and individuals interviewed, respectively.

The information contained in this report is based on the agreed-upon scope of our work, and information we obtained from various procedures including: reading and analyzing documentation and electronic information provided by CCH; interviewing key personnel from CCH, Cook County, CountyCare, CountyCare's third-party administrator Evolent Health ("Evolent"), and CCH's external auditor RSM US LLP ("RSM"); and other procedures described in more detail below.

## II. Background of CountyCare

Because the primary focus of the OIIG Letter relates to CountyCare, a department of CCH, it is useful to provide an overview of the history, operations and financial results of CountyCare before addressing the specific OIIG findings and recommendations.

### A. History and Formation of CountyCare

CountyCare was formed in 2012 when CCH received a Federal waiver under Section 1115 of the Social Security Act.[4] CountyCare began as a demonstration project under State of Illinois (the "State") Medicaid program that ran through June 30, 2014, at which time CountyCare became a County Managed Care Community Network ("MCCN") and its members were transitioned. The formation of CountyCare enabled residents of Cook County who became eligible for Medicaid under the Patient Protection and Affordable Care Act (commonly known as the ACA or Obamacare), and may already have been receiving medical services from CCH in the form of uncompensated care, to join CountyCare.[5]

### B. Membership Growth

During the initial years of CountyCare's operations under the waiver program, it had approximately 60,000 members. After Medicaid expansion in 2014, membership grew from under 100,000 to over 150,000. In 2017, following a request for proposal ("RFP") process, the State awarded seven contracts to provide Medicaid Managed Care in Cook County. CCH acquired membership of Family Health Network as of November 1, 2017, and the membership of Aetna Better Health of Illinois[6] was transitioned to CountyCare as of January 1, 2018, which caused membership to more than double compared to before these transitions. Over the following several months, CountyCare's membership stabilized at approximately 330,000. During the first half of 2019, as Medicaid enrollment declined statewide,

[4] CCH Financial Report, November 30, 2016, at p. 3.
[5] CCH Financial Report, November 30, 2018, at Notes 2 and 16.
[6] Family Health Network and Aetna Better Health of Illinois are MCCNs that formerly operated in Illinois.


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membership has declined at CountyCare to under 320,000. A graph showing monthly membership of CountyCare is attached at **Appendix 3**.

### C. Premium Revenue

Like other Medicaid MCCNs, CountyCare receives revenue in the form of premium payments from the State. The premiums are paid on a per member per month ("PMPM") basis, which is also referred to as capitation. The PMPM premium varies based on the type of member (i.e., Affordable Care Act, Family Health Plan, Integrated Care Program or Managed Long-Term Service and Support), as well as demographics of the member (e.g., age, gender). During fiscal year 2018, the average PMPM premium was approximately $450.[7]

The premium amounts are set annually by the State based on a variety of factors, including cost information submitted by each of the MCCNs. Because CCH is a unit of Cook County Government, CountyCare's premium revenues from the State are paid to Cook County rather than to CCH or CountyCare. Premium payments are typically made to health insurers at the beginning of each month for members who have coverage in that month, with any necessary adjustments being made in the subsequent months.

The State has not always made the premium payments timely. In 2016, when the State did not have an approved budget it was unable to pay the monthly premium payments to Cook County for the benefit of CountyCare in a timely fashion. Also, during the summer of 2017, the State made an adjustment to lower the premium rates it was paying for CountyCare members retroactive to January 1, 2016 through June 30, 2017. This retroactive rate adjustment is commonly referred to as the claw back because the State withheld and/or reduced monthly premium payments made to CountyCare. This claw back caused significant cash flow challenges for Cook County and CountyCare as the cash inflows from the State that were expected, and were intended, to be used to pay medical claims to other providers for care of CountyCare members was reduced in excess of $80 million over several months, with no advance notice. As a result of payment delays and the claw back from the State, CountyCare delayed many of the claims payments owed to providers during fiscal years 2016 and 2017.

[7] Based on discussion with and data provided by CountyCare Director of Finance; calculated as annual PMPM revenue divided by member months.



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### D. MOU Between CCH and CountyCare

CCH is CountyCare's largest provider of medical services.[8] Although not required to do so, CountyCare and CCH entered into a formal Memorandum of Understanding (the "MOU") in July 2014. The terms of the MOU and subsequent amendments set forth how CCH was to record reimbursement for medical services provided to CountyCare members. It is important to note that CountyCare does not make cash payments to CCH for services rendered to CountyCare members.

It is standard industry practice for hospitals to maintain a charge master, which includes a charge amount for each service such as a standard room rate for an inpatient stay, specific diagnostic procedures, physician examinations, etc. The amounts set forth in the charge master, which are also commonly referred to as charges, gross charges or full charges (hereinafter referred to as, "charges"), are typically higher than the amounts that are actually paid by government payers, commercial insurers and health plans.

Under the terms of the original MOU, CountyCare compensated CCH for services provided to CountyCare members at 100% of charges.[9] This resulted in higher than normal reimbursement for CCH and higher medical claims costs for CountyCare.[10]

The MOU also contemplated that the CCH reimbursement rate would be lowered to 75% of charges effective as of December 1, 2015.[11] In February 2018, CCH and CountyCare entered into an amendment to the MOU which further lowered the CCH reimbursement rate to 26% of charges, retroactively effective to December 1, 2016, which is more consistent with market rates,[12] in an effort to reduce the medical claims costs being recognized in response to the reduction in rates (i.e., the claw back) put in place by the State at that time. On January 22, 2019, CCH and CountyCare entered into another amendment to the MOU to increase the reimbursement rate to CCH to 70% of charges, effective as of the beginning of fiscal year 2018.

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[8] CCH provided approximately 14% of services (based on net patient services revenue) to CountyCare members in fiscal year 2018. Per CountyCare Director of Finance, CountyCare's next-largest provider comprises approximately 4.5% of services.

[9] The reimbursement rate can be set based on CCH and CountyCare management's discretion, but cannot exceed charges.

[10] We have been advised that the reimbursement amount has historically been adjusted to reflect the cost of providing the services.

[11] MOU dated July 1, 2014, Attachment A.

[12] Based on hospital paid claims data provided by CountyCare Director of Finance, CountyCare reimburses external providers at an average rate of 21% of charges.



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Because CountyCare is part of CCH, no cash payments are made by CCH to CountyCare for these medical claims. Instead, intra-account[13] due to / due from are recorded within the general ledger of each account and these intra-account amounts are eliminated in the preparation of CCH's overall financial statements such as those presented in the annual audited financial statements, consistent with accounting principles generally accepted in the United States ("GAAP").[14]

### E. Medical Claims Processing and Payment

CountyCare has retained the services of a third party administrator ("TPA") to process and pay claims and perform other related services. This is a common practice for many health plans. The current TPA is Evolent Health, which acquired CountyCare's predecessor TPA, Valence Health.

Most of the health care providers that treat CountyCare members submit claims electronically to Evolent. Evolent then processes and adjudicates (i.e., determines the amount due and approves) the claims so the medical provider can be paid for the services it has rendered to CountyCare members. CountyCare pays most providers based on the Medicaid fee schedule set by the State. The claims payment process includes the periodic submission of invoices for each provider by CountyCare to CCH for review and approval. We have been informed by CCH officials that this process typically requires 3 to 4 days, or in some cases where there are questions to be addressed, 7 days. Once the CCH review and approval process is completed, the invoices are forwarded to Cook County for further review and approval.

Evolent maintains a disbursement account that is used to pay medical claims on behalf of CountyCare. This disbursement account is funded through cash transfers from Cook County. An initial deposit of $25 million was made to this disbursement account, which was subsequently increased to $50 million in fiscal year 2018, commensurate with the growth of the plan. This deposit is reported on CCH's Statement of Net Position[15] (i.e., the balance sheet) as an asset. As previously stated, CountyCare's premium payments from the State are made to Cook County. Accordingly, CountyCare, and Evolent as its TPA, are dependent upon the ability of Cook County to provide cash to pay medical providers. There have been times over the past several years when Cook County did not have sufficient cash available to transfer to CountyCare / Evolent to pay medical claims due. We have been informed by Cook County officials that

[13] As used in this document "intra-account" refers to transactions between CCH's operating units (Stroger, CountyCare, etc.), as opposed to transactions between general ledger or bank accounts.
[14] CCH Financial Report, November 30, 2018, at Note 3 and the Combining Statement of Net Position of Operating Account Information.
[15] CCH Financial Report, November 30, 2018, at Statement of Net Position.



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the lack of available cash has been caused by delays and / or reductions in premium payments from the State,[16] as well as other cash flow and appropriation authority constraints at Cook County and CCH.

### F. CCH Accounting and Financial Reporting

CCH, which includes CountyCare, maintains its own Board of Directors, prepares separate financial statements and is also included in the Cook County Combined Annual Financial Report. CCH operates as an enterprise fund of Cook County and is financed and operated in a manner similar to private business enterprises; the intent of the governing body is that the costs of providing goods and services to the general public on a continuing basis be financed through revenue from user fees.[17]

In order to understand and assess CCH's financial results, it is important to understand the basis upon which such results are reported. As an enterprise fund, CCH is required under GAAP as promulgated by the Governmental Accounting Standards Board ("GASB") to use the accrual basis of accounting. Under accrual accounting, revenues are recognized when earned, and expenses are recorded when incurred regardless of the timing of related cash flows.[18] For the CCH healthcare providers, this means that revenues are recognized at their net realizable amount when the medical services are rendered rather than at a later date when the patient or third-party payer is invoiced or pays the invoice. Accounts receivable are recognized by CCH for patient services at the time services are rendered, not when cash is received. CountyCare similarly recognizes premium revenue from the State when it is earned, which is the period during which members have coverage. Consistent with typical health insurance arrangements, the State sets eligibility for CountyCare members at the beginning of each month. For example, in early November the State would provide a roster of covered members who are eligible for that month. Under normal circumstances, the State would pay the premiums for these eligible members in early November. Accordingly, there should be no amount of premium receivable as of the end of any month, other than for adjustments for members added or dropped during the prior month. As of November 30, 2018, CountyCare's premiums receivable from the State were $14.6 million,[19] which is much less than CountyCare's average monthly premium revenue earned of approximately $152 million.[20]

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[16] Refer to Appendix 4 for a chart illustrating timing of PMPM payments received from the State, as well as timing of payment of medical claims.
[17] CCH Financial Report, November 30, 2018 at Note 1.
[18] CCH Financial Report, November 30, 2018 at Note 3.
[19] CCH Financial Report, November 30, 2018, at Statement of Net Position.
[20] Fiscal year 2018 CountyCare capitation of $1,822,414,772 / 12 months = $151,867K; Cook County Health and Hospitals System of Illinois Financial Report, November 30, 2018, at Statement of Revenues, Expenses and Changes in Net Position.


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### G. Medical Claims Payable

As required by GAAP accrual accounting, CountyCare records expenses for claims related to medical services provided to members at the time the services are rendered. As of November 30, 2018, claims payable to providers outside of CCH was $502 million.[21] This claims payable includes amounts for claims submitted by health care providers that have been received and are being processed and claims that have been processed but not yet paid totalling $277 million, and claims that have been incurred but not yet reported totalling $225 million.

During fiscal year 2018 and fiscal year 2019 to date, CountyCare has been able to process more than 90% of the clean claims submitted within 30 days of receipt, in all but one month.[22] However, as previously noted, in recent years there has, at times, not been sufficient cash available for CountyCare's TPA to pay the medical claims once they have been processed. We understand this cash shortage has been caused by delays in premium payments from the State as well as other cash flow and appropriation authority constraints at Cook County. A graph showing the timeliness of claims adjudicated and paid, along with the timing of State premium payments is at **Appendix 4**.

As of November 30, 2018, $160 million[23] of the $277 million claims payable represented medical claims that have been processed but not yet paid. Of this $160 million, claims totalling $26 million (16%) have been in the adjudicated but not paid status for more than 90 days, which is longer than would be expected for most health plans. An aging of the claims adjudicated but not paid as of November 30, 2018 and 2017 is shown in **Appendix 4**.

### H. Incurred But Not Reported Claims Payable

As previously stated, CountyCare is required under GAAP to accrue a claims payable liability for medical services provided to its members before the end of its fiscal year, even though those claims may not have been submitted for payment as of that date. For example, a member may have been treated at an area hospital and discharged on November 27 and the hospital may not submit the claim to CountyCare for another 30 days. Nonetheless, CountyCare must recognize (i.e., accrue) this expense and related liability as of November 30.[24] This portion of the claim payable is known as "incurred but not reported" and is commonly referred to as "IBNR". IBNR is an actuarially determined estimate based on the plan's past experience and other factors. CountyCare, like many health plans, uses an outside actuarial firm,

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[21] CCH Financial Report, November 30, 2018, at Statement of Net Position.
[22] See Appendix 4.
[23] Milliman Inc. "Claim Liability Estimates and Methodology CCHHS' CountyCare Health Plan Financial Reporting As of November 30, 2018", at Table 1.
[24] We have been advised that CountyCare permits medical providers to submit claims up to six months after the date of service, consistent with State Medicaid guidelines.



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Milliman Inc. (“Milliman”), to quantify the estimated IBNR. The IBNR is also subject to audit procedures performed by CCH’s independent auditor RSM in connection with RSM’s audit of the financial statements of CCH. Our team’s health actuaries have also analyzed Milliman’s quantification of IBNR as of November 30, 2018 and found it to be a reasonable estimate utilizing standard industry methodologies, recognizing that actual claims runout will vary due to normal statistical and environmental factors.

### I. Intra-Account Liability with CCH Medical Providers

CCH’s medical providers represent the largest provider of care to CountyCare members. As discussed above, the MOU sets the rates at which CountyCare reimburses CCH’s hospital for these services. Because CCH and CountyCare are part of the same legal entity, and because Cook County holds all cash on behalf of CCH, there is no need for a cash payment or transfer from CountyCare to its hospital, John H. Stroger, Jr. Hospital (“Stroger”), for the medical services it provides. Instead, accounting entries are recorded by CCH in the Stroger account to recognize the revenue for the medical services provided and a corresponding intra-account receivable, while CountyCare records the claims expense and corresponding intra-account liability. All of these amounts are then eliminated in the combination of the accounts in presenting the combined financial statements of CCH.[25]

As of the fiscal year ended November 30, 2018, the amount of intra-account medical claims liability was $199 million. This amount represents the medical services provided by Stroger to CountyCare members during the fiscal year, recorded at 70% of Stroger’s charges. This amount is reported as an intra-account liability in the November 30, 2018 Statement of Position for CountyCare and then is eliminated in the combined financial statements. As noted above, this liability is not paid in cash and therefore should not be considered a required outlay of cash.

### J. Operating Results of CountyCare

CountyCare’s premium revenues from the State have exceeded its expenses, including medical claims and administrative costs in each of the past three fiscal years on an accrual basis, as shown in the table below.

[25] CCH Financial Report, November 30, 2018, at Note 3, Combination describes the intra-account eliminations, which can also be seen in the Combining Statement of Net Position of Operating Accounts Information and Combining Schedule of Revenues and Expenses, and Changes in Operating Accounts Information.



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**Table 1: CountyCare's Operating Results Fiscal Year 2015-2018[26]**

| | 2015 | 2016 | 2017 | 2018 | Total |
|---|---|---|---|---|---|
| **Operating revenues:** | | | | | |
| CountyCare capitation | $ 861,572,979 | $ 924,829,566 | $ 836,537,764 | $ 1,822,414,772 | $ 4,445,355,081 |
| | | | | | |
| **Operating expenses:** | | | | | |
| External medical claims [1] | 660,300,874 | 665,035,256 | 652,288,716 | 1,543,955,887 | 3,521,580,733 |
| Stroger medical claims | 242,503,768 | 187,277,492 | 85,485,275 | 199,227,092 | 714,493,627 |
| Other operating expenses [2] | 7,307,523 | 59,307,738 | 54,022,683 | 75,729,642 | 196,367,586 |
| ***Total operating expenses*** | ***910,112,165*** | ***911,620,486*** | ***791,796,674*** | ***1,818,912,621*** | ***4,432,441,946*** |
| | | | | | |
| **Operating (loss) gain** | **$ (48,539,186)** | **$ 13,209,080** | **$ 44,741,090** | **$ 3,502,151** | **$ 12,913,135** |

[1] External medical claims refers to medical claims from providers outside of CCH. These are described as "foreign claims" on CCH's financial statements
[2] We understand that some expenses reported as Other operating expenses in 2016 through 2018 are included in medical claims in 2015

Since fiscal year 2016, CountyCare has reported operating gains, even in years when it had above market reimbursement for Stroger, its largest provider of medical services. The table below summarizes what CountyCare's operating gains would have been if the reimbursement rate for Stroger[27] was based on 26% of charges.

**Table 2: CountyCare Pro Forma Operating Results Fiscal Years 2015-2018[28]**

| | 2015 | 2016 | 2017 | 2018 | Total |
|---|---|---|---|---|---|
| **Operating revenues:** | | | | | |
| CountyCare capitation | $ 861,572,979 | $ 924,829,566 | $ 836,537,764 | $ 1,822,414,772 | $ 4,445,355,081 |
| | | | | | |
| **Operating expenses:** | | | | | |
| External medical claims [1] | 660,300,874 | 665,035,256 | 652,288,716 | 1,543,955,887 | 3,521,580,733 |
| Stroger medical claims at 26% of charges | 63,050,980 | 64,922,864 | 85,485,275 | 73,998,634 | 287,457,753 |
| Other operating expenses [2] | 7,307,523 | 59,307,738 | 54,022,683 | 75,729,642 | 196,367,586 |
| ***Total operating expenses*** | ***730,659,377*** | ***789,265,858*** | ***791,796,674*** | ***1,693,684,163*** | ***4,005,406,072*** |
| | | | | | |
| **Operating (loss) gain** | **$ 130,913,602** | **$ 135,563,708** | **$ 44,741,090** | **$ 128,730,609** | **$ 439,949,009** |

[1] External medical claims refers to medical claims from providers outside of CCH. These are described as "foreign claims" on CCH's financial statements
[2] We understand that some expenses reported as Other operating expenses in 2016 through 2018 are included in medical claims in 2015

**Appendix 5** details the revenues and expenses on an as-reported and pro-forma basis for each of the past four fiscal years and in total for that period.

[26] Refer to Appendix 5.
[27] CCH Financial Report, November 30, 2018, includes combining schedules of revenues, expenses, and changes in net position of operating accounts. These schedules specifically spell out intra-account medical claims expenses between CCH and Stroger, which we used as the basis for creating Tables 1 and 2.
[28] Refer to Appendix 5.



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### K. Cook County Funding of CCH

CCH's allocation of Cook County tax revenues has declined over the past seven years from $250 million in fiscal year 2012 to $69 million in fiscal year 2018.[29] Total contributions from Cook County, including capital contributions and transfers in, declined from $329 million to $180 million in the same period. CountyCare has contributed to CCH's decreased dependence on funding from Cook County because many patients who would have received uncompensated care in the past are now covered by CountyCare, as well as because CountyCare operating gains are available to cover other CCH costs.[30] Although CCH's dependence on Cook County has declined, it still needs funding to cover the costs of operating CCH programs such as the Department of Public Health and Correctional Health Services, which do not have another revenue source. Furthermore, even with Medicaid expansion, as the area's public safety-net hospital that treats all patients regardless of ability to pay, Stroger still provides a very high level of uncompensated care. In fiscal year 2018, Stroger provided over $500 million of uncompensated care.[31]

A summary of the components of Cook County funding to CCH is included at **Appendix 8** and a summary of uncompensated care is included at **Appendix 7**.

## III. Assessment of OIIG Findings and Recommendations

As described earlier in this report, we have been engaged to assist CCH in its assessment of the findings and recommendations contained in the OIIG Letter. Based on our procedures performed to date, we have made the following observations related to each of the OIIG's findings and recommendations, as discussed herein.

> **OIIG Finding No. 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.**

As an initial point, a more appropriate measure of the ability to pay medical claims payable is to compare it to cash on hand or total current assets – not just PMPM receivable from the State. Under governmental

[29] Refer to Appendix 8 for a summary of funding from Cook County, as reported in CCH's audited financial statements.
[30] Based on discussions with CCH management.
[31] Determined as the sum of CCH's bad debt provision, at cost, and charity care estimated costs incurred, as reported in CCH's audited financial statements. Refer to Appendix 7.



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accounting standards, current assets are defined as "cash and other assets or resources commonly identified as those that are reasonably expected to be realized in cash or sold or consumed within a year."[32] Accordingly, in assessing an organization's ability to pay its outstanding invoices at a point in time, it is important to look not only at the cash the organization currently possesses, but also the amounts which the organization reasonably expects to be converted to cash in the near term.

We analyzed CountyCare's outstanding medical claims payable to external parties as of November 30, 2018,[33] noting that this amount was comprised of the following categories:

**Table 3: CountyCare Medical Claims Payable to External Parties as of November 30, 2018**

| Category | Amount[34] |
|---|---|
| Claims received but unpaid[35] | $276,957,282 |
| Estimate of claims incurred but not yet reported ("IBNR") | 224,603,006 |
| **Total** | **$501,560,288** |

We observed that as of the same date, CCH had cash and cash equivalents totalling $370,685,572, and total current assets (including cash and cash equivalents) of $644,801,409.[36] In addition to CCH's current assets, CCH also had a refundable deposit asset of $50,000,000 with Evolent, its third party administrator; this deposit was available for use by Evolent to pay CountyCare's medical claims.[37]

**Table 4: CCH Cash and Other Current Assets as of November 30, 2018**

| Category | Amount[38] |
|---|---|
| Cash and cash equivalents | $370,685,572 |
| Other current assets | 274,115,837 |
| Total current assets | $644,801,409 |
| Refundable deposit with Evolent | 50,000,000 |
| **Total current assets and Evolent deposit** | **$694,801,409** |

While CCH did not have sufficient cash on hand as of November 30, 2018 to pay all of CountyCare's medical claims liabilities outstanding as of the same date, CCH did have total current assets in excess of

[32] GASB 2200.176.
[33] As of November 30, 2018, CountyCare's medical claims payable due to John H. Stroger, Jr. Hospital was $199,227,092. This intra-account payable does not require cash payment; accordingly, we focused our analysis on claims payable to external parties.
[34] Claims payable detail provided by CountyCare.
[35] Of the total $276,957,282 of claims received but unpaid, $159,708,743 had been processed and were ready to be paid.
[36] CCH Financial Report, November 30, 2018, at p. 11.
[37] CCH Financial Report, November 30, 2018, at Note 16.
[38] CCH Financial Report, November 30, 2018, at p. 11.


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CountyCare's medical claims liabilities.[39] Based on our industry experience working with healthcare providers and payers, it is not uncommon for health insurance companies to have medical claims liabilities in excess of cash on hand at a point in time. We note that insurance companies typically maintain sufficient risk-based capital to cover their estimated claim liabilities and other uncertainties inherent in health plan operations; however, as an MCCN, CountyCare is not required to maintain risk-based capital.[40]

Based on CCH's audited balance sheet at each fiscal year end November 30, 2016, 2017, and 2018, CCH has not had sufficient cash and cash equivalents on hand to pay all of CountyCare's medical claims liabilities outstanding at each fiscal year end November 30, 2018, 2017, and 2016. Moreover, it is our understanding that CountyCare has had to delay payments to medical service providers in recent years as Cook County has not had sufficient cash available for transfer to Evolent to pay all CountyCare claims as they have been processed and adjudicated. As of November 30, 2018, CountyCare had approximately $160 million of claims adjudicated but not yet paid, of which more than two-thirds had been adjudicated but not paid for over 30 days and 16.2% had been adjudicated but not paid for over 90 days.[41] The delays in cash flow and cash shortages are expected to remain the case unless Cook County and CCH can determine how funds can be made available to pay claims more timely. We understand that some of these delays have been caused by delays and/or unexpected reductions in premium payments from the State. We have also been advised that Cook County has cash flow and appropriation authority constraints that prevent funds being available to pay CountyCare's claims when due.

The OIIG Letter also states that CCH "has experienced interruptions in healthcare services due to its inability to pay vendors"[42], which the OIIG appears to suggest is related to CountyCare's unpaid medical claims liabilities. Based on our procedures to date, including interviews with management responsible for CCH's finances, accounting, materials management, purchasing, and accounts payable processing, it is our understanding that although CCH as a healthcare provider may have experienced instances where certain elective procedures were rescheduled due to vendor delays, these issues are unrelated to CountyCare's financial position. Rather, CCH's delays in paying its vendors primarily relate to issues with CCH's vendor contracting or appropriation processes. For example, if a vendor submits an invoice that does not match CCH's purchase order, CCH will not process payment until the invoice is correctly matched to the purchase order. As another example, if a vendor provides services to CCH outside of the

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[39] As of November 30, 2018, CCH had total current liabilities of $808 million, of which $502 million are medical claims payable. Only a portion of the $306 million remaining other current liabilities, such as accounts payable and accrued salaries, would need to be paid within 30-60 days of fiscal year end.

[40] CCH and CountyCare officials informed us that CountyCare is not required to maintain risk-based capital.

[41] Refer to Appendix 4 for an analysis of CountyCare claims adjudicated and paid.

[42] OIIG Letter, p.12.



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contracted scope or period, CCH is unable to process payment until a contract change order is processed. These vendor issues at CCH are unrelated to CountyCare's outstanding medical claims payable.

**OIIG Finding No. 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.**

As previously discussed, CountyCare is required by GAAP to record its revenues and claims liability under the accrual basis of accounting. Accordingly, revenues are recorded in the period earned, and expenses are recorded in the period incurred, regardless of whether cash is exchanged in those periods. In order to assess whether CountyCare's revenues are sufficient to pay all of its health care and administrative expenses each fiscal year, we analyzed CountyCare's premium revenue recorded compared to medical claims expenses in each fiscal year 2015, 2016, 2017, and 2018, as illustrated above in **Table 1**.

As **Table 1** above demonstrates, although CountyCare's medical claims and administrative expenses exceeded revenue from premiums in fiscal year 2015, CountyCare's revenue from premiums exceeded its medical claims and administrative expenses in each subsequent fiscal year through 2018,. Moreover, this table, together with **Appendix 6** demonstrate that CountyCare's medical claims expenses have grown commensurate with growth in membership and corresponding premium revenue.

Notably, the medical claims expense in Table 1 above includes CountyCare's medical claims expenses related to Stroger at the then-current reimbursement rates pursuant to the MOU between CountyCare and CCH. These rates were 100%, 75%, 26%, and 70% of Stroger's charges for fiscal years 2015, 2016, 2017, and 2018, respectively. As will be discussed in greater detail below, based on our analysis and industry experience, a reimbursement rate of 26% of charges is more consistent with the typical Medicaid reimbursement rate for CountyCare's external providers. As such, in Table 2 above, we have prepared a "pro forma" analysis of CountyCare's premium revenue and medical claims and administrative expenses for fiscal years 2015-2018, in which we have adjusted the medical claims expenses related to Stroger to a reimbursement rate of 26% of charges in each fiscal year.

Both Tables 1 and 2 above demonstrate that CountyCare earned premium revenue in excess of medical claims and administrative expenses in each of the past three fiscal year.


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**OIIG Finding No. 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.**

As described in Section II.D above, the MOU between CCH and CountyCare sets forth the reimbursement rates between CountyCare and CCH, including Stroger.[43] In July 2017, following a premium revenue reduction from the State, CountyCare reduced its reimbursement rates for CCH under the MOU to 26% of charges.[44] This change was applied retroactively to all of fiscal year 2017, although CCH and CountyCare did not execute the corresponding amendment to the MOU until February 2018.[45] CCH's July 2017 financial results, presented to the CCH Finance Committee,[46] included financial results for CountyCare which reflected the reduced reimbursement rate. Similarly, the reduced reimbursement rate was reflected in CCH's and CountyCare's monthly financial results presented to the CCH Board of Directors beginning in July 2017 and for each month for the remainder of fiscal year 2017.[47] Although the financial effects of the change in reimbursement rate were presented to CCH's governing bodies, it does not appear that there was clear, written disclosure of the change in reimbursement rate to the CCH Board of Directors or Cook County Board of Commissioners.

It is important to note that the rates set forth under the MOU, as well as any adjustments, are set at the discretion of CCH and CountyCare management and have no impact on the combined financial results of CCH. Under GAAP, preparing combined financial statements (such as the financial statements of CCH, which include the financial position and operating results of Stroger and CountyCare) requires elimination of intra-account transactions and balances.[48] This is precisely what CCH did in its audited financial statements for the year ended November 30, 2018 and in previous years. As an example, in CCH's "Combining Schedule of Revenues, Expenses, and Changes in Net Position of Operating Accounts Information", CCH eliminated the intra-account revenue Stroger earned as reimbursements

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[43] As previously noted, the reimbursement rate can be set based on CCH and CountyCare management's discretion, but cannot exceed charges.
[44] Amendment to MOU dated February 6, 2018.
[45] Amendment to MOU dated February 6, 2018.
[46] The CCH Finance Committee "reviews the income and expenditures of Cook County Health, advises the Chief Executive Officer, Chief of Clinical Integration and Chief Financial Officer in preparation of the budget, reviews the proposed budget in advance of presentation to the Cook County Health Board, and makes recommendations to the board on all financial matters." https://cookcountyhealth.org/about/board-of-directors/
[47] https://cookcountyhealth.org/about/board-of-directors/board-committee-meetings-agendas-minutes/
[48] GASB 2200.151.



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from CountyCare ($199,227,092), as well as the corresponding intra-account expense CountyCare incurred for medical claims expenses related to Stroger (also $199,227,092).[49] As a result, since intra-account revenue and intra-account expenses were eliminated in equal amounts, the intra-account activity had no net impact on CCH's combined financial results. Thus, regardless of the rate at which CountyCare reimbursed Stroger, the intra-account transactions between Stroger and CountyCare would have no impact on CCH's financial position or operating results.

**OIIG Finding No. 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.**

The MOU between CCH and CountyCare as originally executed on July 1, 2014 included a reimbursement rate of 100% of CCH's charges for the period July 1, 2014 through November 30, 2015, with rates thereafter to be reduced to 75% of CCH's charges for the period beginning December 1, 2015. Subsequently, in fiscal year 2017, CCH was informed that the State would be reducing the premium revenue paid to CountyCare as a means of retroactive recovery of premiums the State believed had been previously paid in excess to CountyCare.[50] In light of this reduction in revenue, CCH and CountyCare amended the MOU in February 2018, retroactive to December 1, 2016 (i.e., the start of fiscal year 2017), to revise CountyCare's reimbursement rate to CCH for medical claims to 26% of charges, compared to the previous rate of 75%.[51] Later, in fiscal year 2018, CCH and CountyCare again amended the MOU to increase the reimbursement rate to 70% of CCH's charges for the period beginning December 1, 2017. Notably, as described in the preceding section, none of these intra-account reimbursement rate changes have had an impact on the combined financial position or operating results of CCH as presented in CCH's audited financial statements.

Based on our industry experience, as well as our analysis of the existing rates in place between Stroger and other payers and between CountyCare and other providers, Medicaid reimbursement at rates of 70-100% of charges is well above market rates, and much greater than what is paid by other Medicaid health plans and other payers.[52] By contrast, a reimbursement rate of 26% of charges is more consistent with the typical Medicaid reimbursement rates for CountyCare's external providers. As such, rather than having a

[49] CCH Financial Report, November 30, 2018, at page 49.
[50] Minutes of the meeting of the Finance Committee of the CCH Board of Directors held Friday, August 25, 2017.
[51] Minutes of the meeting of the Finance Committee of the CCH Board of Directors held Friday, August 25, 2017.
[52] Summary of Medicaid market reimbursement rates compared to CCH reimbursement rates, July 2014 – December 2018


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"significant negative effect on Stroger", the change in rate in fiscal year 2017 brought CountyCare's reimbursement rate to a level more consistent with other providers' reimbursement rates. Had reimbursement been at 26%, CountyCare would have had a higher margin, but that the overall net result CCH would not have been different.

> **OIIG Finding No. 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.**

We are not aware of circumstances where premium revenue and medical expense allocations are adjusted amongst the accounts outside of the terms of the MOU. As previously described, CCH and CountyCare have amended the terms of the MOU on several occasions, however, the allocation of premium revenue and medical expenses appear to be consistent with the applicable terms of the MOU.

Furthermore, beyond premium revenue and medical expenses, it is our understanding that CCH employs operating officers responsible for each account (i.e., Stroger, Provident, Cermak, etc.) for the management oversight of CCH operating expenses across the various accounts. Namely, CCH employs expense allocation methodologies to align costs with the locations where the related services are rendered.[53] We understand these cost allocation methodologies have been revised over time in an effort to further improve cost alignment. For example, CCH allocates physician salaries based on where physicians spent their time (e.g., at hospitals versus outpatient clinics). Based on the inquiries we have made, CCH appears to be allocating revenue and expenses based on set allocation methodologies, rather than based on "desired financial goals" as the OIIG Letter suggests.

> **OIIG Recommendation No. 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.**

CCH's audited annual financial statements since fiscal year 2016 include supplementary schedules which report the financial information of each operating account, including CountyCare.[54] These supplemental schedules in each year clearly state CountyCare's premium revenue due from the State, outstanding claims payable, premium revenue earned, and medical expenses incurred.

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[53] Discussion with CCH CFO.
[54] CCH Financial Report, November 30, 2016, 2017, and 2018.


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In addition to the information presented on an annual basis in CCH's audited financial statements, CCH provides a monthly report to both the CCH Board of Directors and the Cook County Board of Commissioners, which includes financial and operational information about CCH and CountyCare such as interim income statements, CountyCare membership details, claims payment turnaround time, and revenue cycle metrics.[55] This information presented on a monthly basis is publicly available on CCH's website.[56] We also understand from interviews of CCH management that CCH is currently developing a separate report which will further highlight financial information throughout the year.

Although CCH already presents, on an annual and interim basis, information about CountyCare's financial performance to the CCH Board of Directors, the Cook County Board of Commissioners, and the public, given the increased significance of CountyCare to CCH overall, we suggest that it would be beneficial to expand the disclosures about CountyCare in CCH's audited financial statements, specifically in both the Notes to Financial Statements and Management's Discussion and Analysis. The business operations and financial metrics of a health plan are different than those of a health care provider; as such, by providing additional discussion regarding CountyCare in its audited financial statements, CCH would better enable users of its financial statements to understand CountyCare and its role in the CCH system.

**OIIG Recommendation No. 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.**

In the past three fiscal years, the growth in CountyCare's medical claims expenses has been commensurate with the growth in CountyCare membership and corresponding premium revenues. Refer to **Appendix 6** for an analysis of CountyCare premium revenue, medical claims expenses, medical claims payable, and monthly membership for fiscal years 2016-2018. As **Appendix 6** illustrates, although CountyCare's medical claims expenses nearly doubled from fiscal year 2016 to fiscal year 2018, CountyCare's premium revenue and average monthly membership also doubled in the same period. Notably, CountyCare's claims cost per member[57] decreased from fiscal year 2016 ($5,799) to fiscal year 2018 ($5,224).[58]

[55] https://cookcountyhealth.org/about/board-of-directors/board-committee-meetings-agendas-minutes/
[56] https://cookcountyhealth.org/about/board-of-directors/board-committee-meetings-agendas-minutes/
[57] Calculated as total claims expense divided by average monthly membership.
[58] Appendix 6.


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With respect to CountyCare's medical claims payable, as of November 30, 2018, CountyCare's medical claims payable (excluding intra-account payable to Stroger) was approximately $502 million, of which approximately $225 million represented IBNR, and $277 million represented claims received, but not yet paid. Further, of the $277 million of claims received, approximately $160 million had been adjudicated and were ready to be paid as of November 30, 2018.

**Appendix 6** also analyzes CountyCare's medical claims payable, demonstrating that CountyCare's claims payable per member[59] has increased slightly from fiscal year 2016 ($1,442) to fiscal year 2018 ($1,499), while days claims payable[60] has increased 19 days from 86 days in fiscal year 2016 to 105 days in fiscal year 2018. These figures indicate a slight downward trend in CountyCare's average payment time, which is consistent with our understanding of the payment lags CountyCare has experienced in recent years due to delays in the receipt of premiums from the State, and cash flow and appropriation authority constraints at Cook County. The delays in premiums from the State are particularly apparent in the claims payable results as of November 30, 2017, in which foreign claims payable per member was $1,944, and foreign claims payable in days was 185 days. It is our understanding that these claims payments lagged at the end of fiscal year 2017 because without a budget and due to other cash flow challenges, the State could not pay premiums to CountyCare consistently in a timely fashion.

Importantly, CountyCare regularly analyzes and monitors unpaid claims, and provides monthly updates on unpaid claims and claims turnaround time to the CCH Board of Directors. Refer to **Appendix 4** for an illustration of trends in CountyCare's claims adjudicated and paid, prepared from data reported to CCH's Board of Directors monthly. As **Appendix 4** shows, from November 2017 through May 2019 CountyCare has consistently achieved its goal of adjudicating at least 90% of clean claims in less than 30 days. However, during the same period it has not been able to achieve its goal of paying at least 90% of clean claims in under 30 days. Notably, during the same period, rather than steady monthly payments of premiums by the State, the timing and amounts of payments CountyCare received from the State varied significantly and were often delayed.[61] It is our understanding that in addition to the delays and uncertainty as to timing of premium payments from the State, other cash flow and appropriation authority constraints at Cook County have also impacted CountyCare's ability to pay claims within 30 days.

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[59] Calculated as foreign claims payable divided by average monthly membership.
[60] Calculated as foreign claims payable divided by total claims expense divided by 365.
[61] See Appendix 4.



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**OIIG Recommendation No. 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.**

Based on the information we have obtained through our procedures performed to date, including interviews with CCH management, it is our understanding that the terms of the MOU are set by CCH management and do not require prior approval from the CCH Board of Directors. However, given the significance of the reimbursement rates to each Stroger and CountyCare individually, as components of CCH, we recommend that CCH management inform the CCH Board of Directors prior to entering into subsequent amendments to the MOU.

**OIIG Recommendation No. 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.**

In our procedures performed to date, we have not identified instances in which management used subjective discretion "when determining which operating units should encounter a gain or loss" in CCH's Combining Schedule of Revenues, Expenses, and Changes in Net Position of Operating Accounts Information. Rather, it is our understanding that CCH utilizes expense allocation methodologies to apportion costs amongst its accounts, such as Stroger, Provident, CountyCare, Cermak, etc. Over time, CCH has revised its expense allocation methodologies as circumstances have changed and also to better align costs with where the related services are rendered. For example, CCH has begun allocating information technology ("IT") costs based on IT usage and allocating physician salaries based on where the physicians are spending time (e.g., at hospitals versus outpatient clinics). However, regardless of whether and how CCH allocates its costs amongst its accounts, such allocations have no bearing on CCH's combined financial results as reported in CCH's annual audited financial statements, prepared on an accrual basis of accounting. We are not aware of any revenue items that are allocated or subject to adjustment, other than the reimbursement rates set forth in the MOU between CCH and CountyCare.



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**OIIG Recommendation No. 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.**

We agree that shifting utilization of CCH providers by CountyCare members would likely be beneficial to CCH. However, it is important to note that CCH is already the most prevalent provider of services to CountyCare members, representing approximately 14% of fiscal year 2018 revenue.[62] Further, CountyCare members are permitted to choose where to obtain needed health care services[63] and CCH cannot require or force utilization of its health system services by its health plan members.[64]

CCH can, however, utilize general marketing, educational, and other initiatives with a goal to encourage greater use of CCH providers by CountyCare members. We understand CCH is currently undertaking several such initiatives as part of its articulated strategy to "capture more CountyCare members as referrals by increasing internal referrals for CCHHS specialty and inpatient care."[65] For example, CCH is expanding the services available at CCH outpatient health services (i.e., services available at locations other than Stroger and Provident hospitals), and also facilitating timely access to CCH specialists through means such as e-Consult services.[66] We suggest that CCH continue to focus on such initiatives in fiscal year 2019 and future years.

## IV. Limitations and Restrictions

This report is subject to the terms and conditions of the Engagement Letter, which contains limitations on the performance of our services and our responsibilities.

[62] Per discussion with and financial information provided by CountyCare Director of Finance. Calculated as pharmacy and medical costs related to Stroger, as a percentage of total pharmacy and medical claims.
[63] http://www.countycare.com/find-a-provider.
[64] The ACA requires qualified health plans to ensure a sufficient choice of providers. https://www.hhs.gov/sites/default/files/ppacacon.pdf, at 1311(c)(1)
[65] CCH FY2017-19 Strategic Plan; CCH FY2020-22 Strategic Plan.
[66] https://cookcountyhealth.org/wp-content/uploads/CCHHS-Strategic-Plan-2017-2019-Impact-2020-approved-07-29-16-1.pdf


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Our services were conducted in accordance with the Statement on Standards for Consulting Services established by the American Institute of Certified Public Accountants ("AICPA"). We have not been engaged to perform an evaluation of internal controls and procedures, and our services do not constitute an engagement to provide audit, compilation, review, or attestation services as described in the pronouncements on professional standards issued by the AICPA or any successor standards setting body. Therefore, we are not expressing an opinion or other form of assurance as a result of performing our services. We are not providing legal services, and any advice or recommendation provided should not be relied on as legal advice.

We call your attention to the possibility that other professionals may perform procedures concerning the same information or data, and perhaps the same accounts and records, and reach different findings than Deloitte FAS for a variety of reasons, including the possibilities that additional or different information or data might be provided to them that was not provided to Deloitte FAS, that they might perform different procedures than did Deloitte FAS, or that professional judgments concerning complex, unusual, or poorly documented transactions or matters may differ.

We did not perform any procedures to verify or assess the accuracy of the information provided by or on behalf of CCH. The sufficiency of our procedures performed, and the accuracy and completeness of all data and information provided to Deloitte FAS for the performance of our services, is solely the responsibility of CCH. Consequently, we make no representation regarding the sufficiency of the procedures performed. CCH is solely responsible for, among other things, evaluating the adequacy and results of our services.

This report is solely for CCH's benefit and is not intended to be relied upon by any person or entity other than CCH. This report shall not be disclosed, quoted, or referenced, in whole or in part, to any person or entity except any regulatory authority with jurisdiction over the business or financial affairs of CCH. This report should be read in its entirety, and we are not responsible for any portion of this report that is selectively quoted or otherwise used in isolation or any summary or paraphrasing of the report that is prepared by others.


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Our procedures and observations are based upon information provided to Deloitte FAS as of the date of this report. We reserve the right to amend this report if we are requested to perform additional procedures or additional information relevant to our procedures and observations becomes available.

Very truly yours,

Steven F. Stanton, Managing Director
Deloitte Financial Advisory Services LLP



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## Appendix 1: Information Received

In connection with the Assessment, we obtained and analyzed certain accounting, financial, and other related information, including, but not limited to, information analyzed by the OIIG.

1. OIIG Letter dated June 21, 2019
2. CCH Audited Financial Statements for the fiscal years ended November 30, 2012, 2013, 2014, 2015, 2016, 2017, and 2018
3. Cook County Comprehensive Annual Financial Reports ("CAFR") for fiscal years 2016, 2017, and 2018
4. CCH trial balance data for fiscal years 2016, 2017, and 2018
5. Summary of CountyCare's claims payable as of November 30, 2016, 2017, and 2018
6. Third-party administrator outstanding claims reports, including aging analyses, as of November 30, 2016, 2017, and 2018
7. Milliman Inc. actuarial reports as of November 30, 2016, 2017, and 2018
8. CountyCare claims data for claims adjudicated but not paid as of November 30, 2017, November 30, 2018, and July 31, 2019
9. Memorandum of Understanding between CCH and CountyCare dated July 1, 2014, and amendments thereto dated February 6, 2018 and January 22, 2019, respectively
10. Monthly Bureau of Finance Revenue Reports presented to the Cook County Board of Commissioners, for the period December 2015 through May 2019
11. CCH Monthly Reports to the Cook County Board of Commissioners for the period January 2018 through July 2019
12. Select monthly reports to the CCH Board of Directors, including reports to the Finance Committee and Managed Care Committee, which are publicly available: https://cookcountyhealth.org/about/board-of-directors/board-committee-meetings-agendas-minutes/
13. CCH Strategic Plan for Fiscal Years 2017-2019; CCH Strategic Plan for Fiscal Years 2020-2022
14. Summary of CCH accounts receivable for fiscal years 2016, 2017, and 2018
15. Summary of CCH rates in place with various hospitals during the period fiscal year 2016 through 2019
16. Summary of Medicaid market reimbursement rates compared to CCH reimbursement rates, July 2014 – December 2018
17. Select email correspondence amongst CCH personnel regarding procurement with vendors
18. Summary of PMPM amounts and dates received by CountyCare from State of Illinois, December 2016 – July 2019


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## Appendix 2: Interviewees

In connection with the Assessment, we conducted informational and fact-finding interviews with the following individuals with knowledge related to this matter, including, but not limited to, individuals interviewed by the OIIG. Some of these individuals were interviewed multiple times.

1. Hill Hammock, Chairman of the Board, CCH
2. Dr. John Jay Shannon, CEO, CCH
3. Ekerete Akpan, CFO, CCH
4. Doug Elwell, Former Deputy CEO of Finance and Strategy, CCH
5. Dorothy Loving, Executive Director of Finance, CCH
6. Percy Moss, Director of Financial Control, CCH
7. Debra Carey, Deputy CEO of Operations, CCH
8. Kathy Lorenc, Director of Strategic Sourcing & Procurement, CCH
9. Charles Jones, Chief Procurement Officer, CCH
10. James Kiamos, CEO, CountyCare
11. Aaron Galeener, Director of Finance, CountyCare
12. Ammar Rizki, CFO, Cook County
13. Lawrence Wilson, Comptroller, Cook County
14. Shakeel Qureshi, Director of Financial Control, Cook County
15. Ivana Dabizljevic, Director of Financial Control, Cook County
16. Katie Benedict, VP of Market Operations, Evolent Health
17. Gerald Sajdak, Director of Client Finance, Evolent Health
18. Patrick Kitchen, Partner, RSM
19. Linda Abernethy, Partner, RSM
20. Erik Ginter, Manager, RSM


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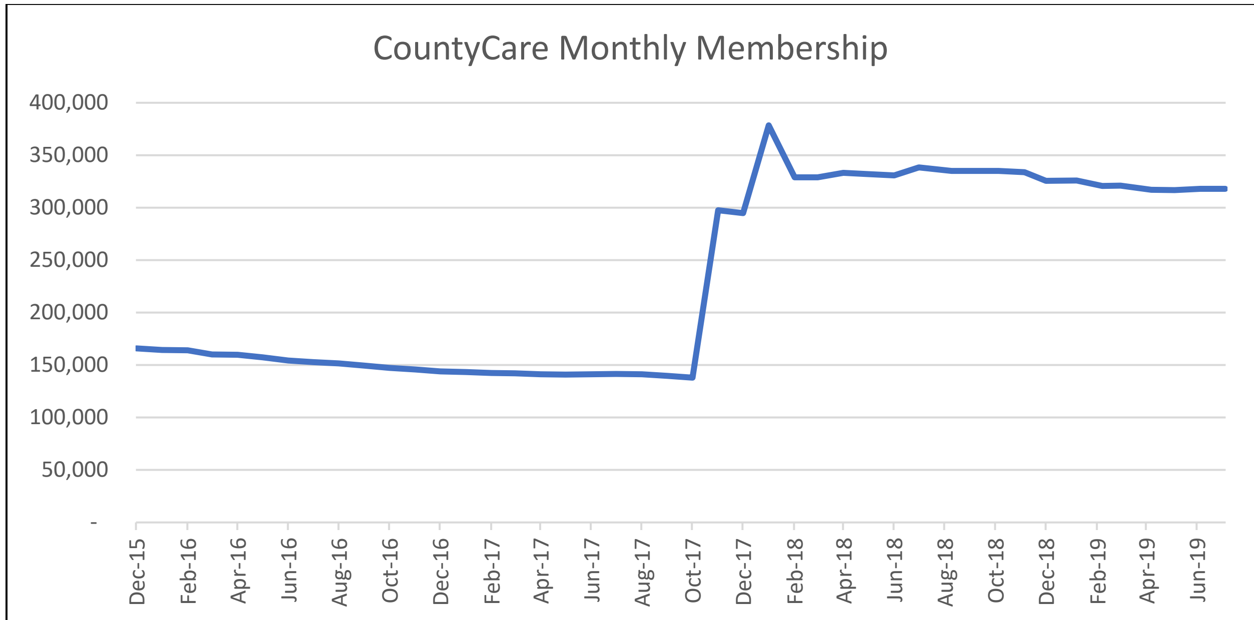
## Appendix 3: CountyCare Membership




*Source: Monthly Reports to the Cook County Board of Commissioners and Monthly Reports to CCH Board of Directors*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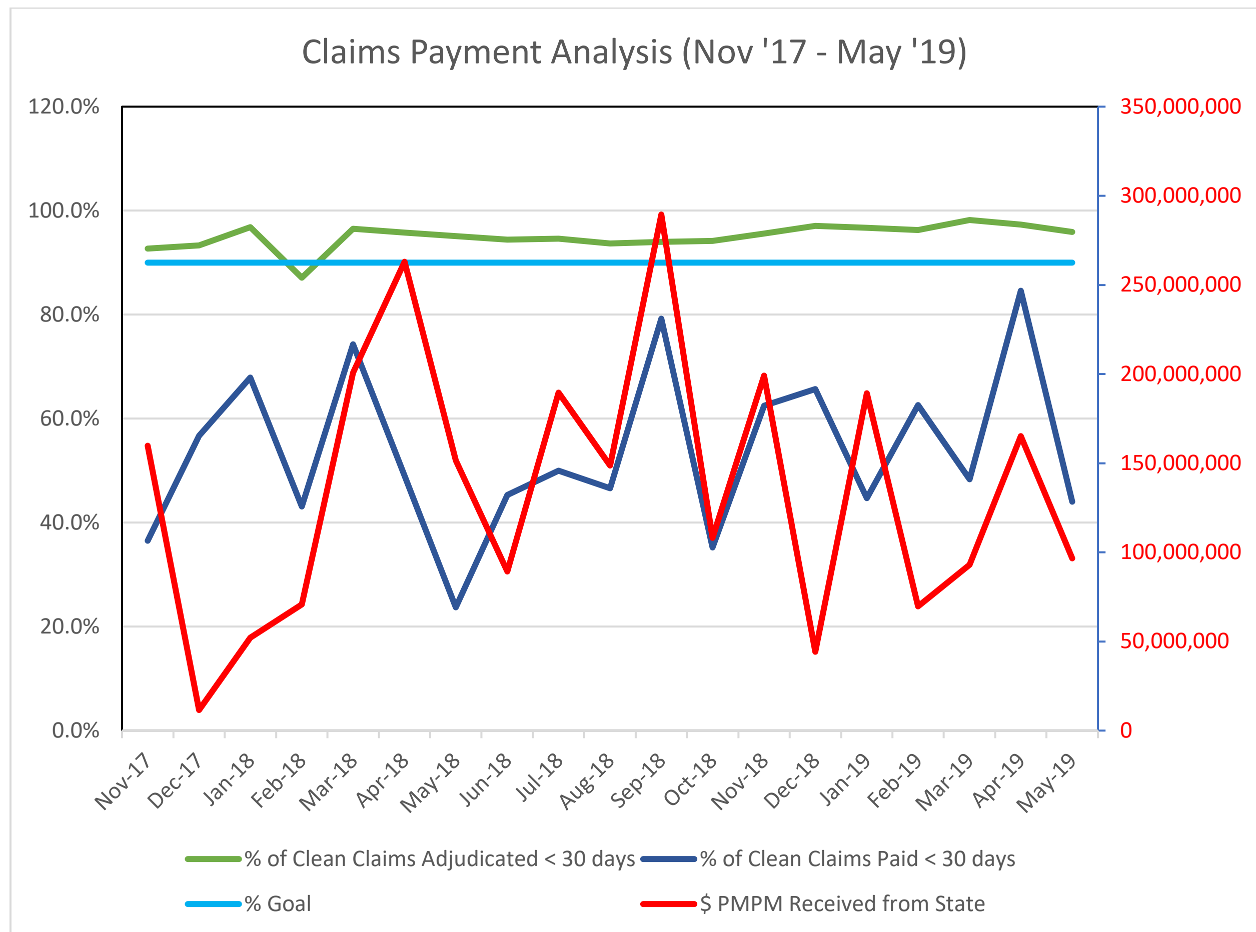
**Appendix 4: Analyses of Claims Adjudicated but not Paid**

***Aging of Medical Claims Adjudicated but not Paid ("ABNP") as of November 30, 2017 and 2018***

| | 2017 | | 2018 | |
|---|---|---|---|---|
| **Number of Days ABNP** | **Claims Amount** | **Claims Amount %** | **Claims Amount** | **Claims Amount %** |
| 0-30 | $ 8,108,807 | 7.10% | $ 50,529,000 | 31.64% |
| 31-60 | $ 29,329,813 | 25.70% | $ 50,232,439 | 31.45% |
| 61-90 | $ 26,021,433 | 22.80% | $ 33,021,567 | 20.68% |
| 91-180 | $ 47,686,987 | 41.78% | $ 24,824,530 | 15.54% |
| 181-365 | $ 2,888,859 | 2.53% | $ 1,115,085 | 0.70% |
| Over 365 | $ 93,089 | 0.08% | $ (13,879) | - 0.01% |
| **Grand Total** | **$ 114,128,988** | **100.00%** | **$ 159,708,742** | **100.00%** |

*Source: Claims data provided by Milliman, Inc.*

***Analysis of Claims Adjudicated and Paid, November 2017 through May 2019***




*Source: Monthly CCH Managed Care Committee Reports; Summary of PMPM Received from State*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## Appendix 5: CountyCare As Reported and Pro Forma Income Statement – Stroger Medical Claims Calculated at 26% of Charges

### As Reported

| | 2015 | 2016 | 2017 | 2018 | Total |
|---|---|---|---|---|---|
| **Operating revenues:** | | | | | |
| CountyCare capitation | $ 861,572,979 | $ 924,829,566 | $ 836,537,764 | $ 1,822,414,772 | $ 4,445,355,081 |
| | | | | | |
| **Operating expenses:** | | | | | |
| External medical claims [1] | 660,300,874 | 665,035,256 | 652,288,716 | 1,543,955,887 | 3,521,580,733 |
| Stroger medical claims | 242,503,768 | 187,277,492 | 85,485,275 | 199,227,092 | 714,493,627 |
| Other operating expenses [2] | 7,307,523 | 59,307,738 | 54,022,683 | 75,729,642 | 196,367,586 |
| ***Total operating expenses*** | ***910,112,165*** | ***911,620,486*** | ***791,796,674*** | ***1,818,912,621*** | ***4,432,441,946*** |
| | | | | | |
| **Operating (loss) gain** | **$ (48,539,186)** | **$ 13,209,080** | **$ 44,741,090** | **$ 3,502,151** | **$ 12,913,135** |

[1] External medical claims refers to medical claims from providers outside of CCH. These are described as "foreign claims" on CCH's financial statements
[2] We understand that some expenses reported as Other operating expenses in 2016 through 2018 are included in medical claims in 2015

*Source: CCH Audited Financial Statements for the years ended November 30, 2016, 2017, and 2018*

### Pro-Forma – Stroger Claims Calculated at 26% of Charges

| | 2015 | 2016 | 2017 | 2018 | Total |
|---|---|---|---|---|---|
| **Operating revenues:** | | | | | |
| CountyCare capitation | $ 861,572,979 | $ 924,829,566 | $ 836,537,764 | $ 1,822,414,772 | $ 4,445,355,081 |
| | | | | | |
| **Operating expenses:** | | | | | |
| External medical claims [1] | 660,300,874 | 665,035,256 | 652,288,716 | 1,543,955,887 | 3,521,580,733 |
| Stroger medical claims at 26% of charges | 63,050,980 | 64,922,864 | 85,485,275 | 73,998,634 | 287,457,753 |
| Other operating expenses [2] | 7,307,523 | 59,307,738 | 54,022,683 | 75,729,642 | 196,367,586 |
| ***Total operating expenses*** | ***730,659,377*** | ***789,265,858*** | ***791,796,674*** | ***1,693,684,163*** | ***4,005,406,072*** |
| | | | | | |
| **Operating (loss) gain** | **$ 130,913,602** | **$ 135,563,708** | **$ 44,741,090** | **$ 128,730,609** | **$ 439,949,009** |

[1] External medical claims refers to medical claims from providers outside of CCH. These are described as "foreign claims" on CCH's financial statements
[2] We understand that some expenses reported as Other operating expenses in 2016 through 2018 are included in medical claims in 2015

*Source: CCH Audited Financial Statements for the years ended November 30, 2016, 2017, and 2018. Stroger medical claims recalculated in 2015, 2016, and 2018 to reflect 26% of charges. Since 2017 Stroger medical claims were recorded at 26% of charges, no changes were made.*

### Calculation of Stroger Claims at 26% of Charges

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| Stroger medical claims as reported [A] | 242,503,768 | 187,277,492 | 85,485,275 | 199,227,092 |
| Reimbursement rate as reported [B] | 100% | 75% | 26% | 70% |
| Stroger medical claims at charges [C] = [A]/[B] | 242,503,768 | 249,703,323 | 328,789,519 | 284,610,131 |
| Pro forma reimbursement rate [D] | 26% | 26% | 26% | 26% |
| Stroger medical claims at 26% [E] = [C] x [D] | 63,050,980 | 64,922,864 | 85,485,275 | 73,998,634 |


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## Appendix 6: Analysis of Claims Payable

| | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|
| **Capitation Revenues:** | | | | |
| CountyCare Capitation | $ 861,572,979 | $ 924,829,566 | $ 836,537,764 | $ 1,822,414,772 |
| ***Total Capitation Revenues* [B]** | ***861,572,979*** | ***924,829,566*** | ***836,537,764*** | ***1,822,414,772*** |
| | | | | |
| **Claims Expenses:** | | | | |
| Foreign Medical Claims | 660,300,874 | 718,027,744 | 652,288,716 | 1,543,955,887 |
| Stroger Medical Claims | 242,503,768 | 187,277,492 | 85,485,275 | 199,227,092 |
| ***Total Claims Expenses* [A]** | ***902,804,642*** | ***905,305,236*** | ***737,773,991*** | ***1,743,182,979*** |
| | | | | |
| **Claims Payable:** | | | | |
| Claims Payable **[D]** | 176,614,807 | 212,778,304 | 372,936,988 | 501,560,288 |
| Stroger Medical Claims | 242,503,768 | 187,277,492 | 85,485,275 | 199,227,092 |
| ***Total Claims Payable*** | ***419,118,575*** | ***400,055,796*** | ***458,422,263*** | ***700,787,380*** |
| | | | | |
| **Average Membership:** | | | | |
| Annual Average Monthly Membership **[C]** | 152,087 | 156,102 | 154,450 | 333,714 |
| Trailing 3mo. Average Monthly Membership **[E]** | 166,513 | 147,562 | 191,805 | 334,623 |
| | | | | |
| **Ratios** | | | | |
| Medical Loss Ratio **[A]/[B]** | 104.8% | 97.9% | 88.2% | 95.7% |
| Claims Cost Per Member **[A]/[C]** | 5,936 | 5,799 | 4,777 | 5,224 |
| Claims Payable Per Member (Foreign) **[D]/[E]** | 1,061 | 1,442 | 1,944 | 1,499 |
| Days Claims Payable (Foreign) **[D]/([A]/365)** | 71 | 86 | 185 | 105 |

*Source: Revenue, expense, and claims payable information sourced from CCH Audited Financial Statements for the years ended November 30, 2016, 2017, and 2018. Monthly membership sourced from Monthly Reports to the Cook County Board of Commissioners and Monthly Reports to CCH Board of Directors.*



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**Appendix 7: Analysis of Uncompensated Care**

| | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|
| **Uncompensated Care** | | | | | |
| Bad Debt at Cost | 139,640,056 | 139,000,205 | 156,583,424 | 200,070,943 | 154,365,963 |
| Estimated Costs Incurred of Charity Care | 173,942,176 | 265,739,453 | 281,015,133 | 273,297,481 | 347,866,711 |
| | | | | | |
| ***Total Uncompensated Care*** | ***313,582,232*** | ***404,739,658*** | ***437,598,557*** | ***473,368,424*** | ***502,232,674*** |

*Source: CCH Audited Financial Statements for the years ended November 30, 2014, 2015, 2016, 2017, and 2018. Based on discussion with CCH officials, it is our understanding that bad debt is reported in CCH's Audited Financial Statements at charges. In order to analyze the components of uncompensated care on the same bases (at cost), we calculated "Bad Debt at Cost" as bad debt as reported in CCH Audited Financial Statements, multiplied by the ratio of "Estimated costs incurred" over "Charges forgone" as reported in Note 4: Charity Care, to CCH's Audited Financial Statements.*



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## Appendix 8: Summary of Funding from Cook County

| | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|
| **Nonoperating Revenues:** | | | | | | | |
| Property taxes | $ 79,629,731 | $ 73,128,663 | $ 37,346,269 | $ 143,417,429 | $ 123,503,232 | $ 82,312,987 | $ 63,866,237 |
| Sales tax | 57,524,338 | 22,944,367 | - | - | - | - | - |
| Cigarette taxes | 112,546,319 | 150,271,011 | 132,314,773 | 14,290,088 | - | 3,331,185 | - |
| Sweetened beverage taxes | - | - | - | - | - | 16,728,786 | 4,318,754 |
| Interest income | 41,774 | 24,983 | 16,428 | 1,662 | 27,654 | 126,230 | 394,997 |
| | | | | | | | |
| **Total Nonoperating Revenues** | **249,742,162** | **246,369,024** | **169,677,470** | **157,709,179** | **123,530,886** | **102,499,188** | **68,579,988** |
| | | | | | | | |
| Capital contributions | 16,974,126 | 21,859,230 | 6,538,685 | 17,128,696 | 22,356,318 | 68,709,710 | 71,638,543 |
| Transfers in | 3,247,019 | 3,558,667 | 1,551,597 | 62,987,754 | 31,265,415 | 30,697,760 | 39,633,879 |
| Retirement plan contribution [1] | 58,984,999 | 56,840,708 | 58,090,216 | - | - | - | - |
| Capital assets transferred to governmental activities [1] | - | (1,862,622) | - | - | - | - | - |
| | | | | | | | |
| **Total Capital Contributions and Transfers In** | **79,206,144** | **80,395,983** | **66,180,498** | **80,116,450** | **53,621,733** | **99,407,470** | **111,272,422** |
| | | | | | | | |
| **Total Received from Cook County** | **$ 328,948,306** | **$ 326,765,007** | **$ 235,857,968** | **$ 237,825,629** | **$ 177,152,619** | **$ 201,906,658** | **$ 179,852,410** |

*Source: CCH Audited Financial Statements for the years ended November 30, 2012 - 2018*

*Note: [1] "Retirement plan contribution" and "Capital assets transferred to governmental activities" included on CCH's audited financial statements as Nonoperating Revenues; however, it is our understanding that these line items more closely align with Capital Contributions and Transfers In. Accordingly, we have reclassified these line items for purposes of this analysis*



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