ATTACHMENT #1

RSM McGladrey

Cook County Health and Hospitals System

Procedures Performed in Connection with the MedAssets Contract

March 12, 2009

In the event of any inquiries with respect to this report, please contact:

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March 12, 2009

Dr. Luis Munoz, Audit Committee Chairman
Cook County Health and Hospitals System
1900 West Polk Street
Chicago, Illinois 60612

Dear Dr. Munoz,

RSM McGladrey, Inc. (RSM) has performed certain procedures related to the MedAssets Net Revenue Systems, LLC (MedAssets) contract for revenue cycle services. Our services were performed in February and March 2009, in accordance with the terms of our arrangement letter dated February 5, 2009.

This report is intended solely for the information and use of management and the Audit Committee. It is not intended to be and should not be used by anyone other than these specified parties.

RSM appreciates the cooperation extended to us during this engagement and is pleased to be of service to Cook County Health and Hospitals System. If you have any questions concerning this report, please contact me at 312.634.3341.

Sincerely

Tim Heinrich
Director

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1. EXECUTIVE OVERVIEW

Introduction

We have performed certain procedures related to the MedAssets Net Revenue Systems, LLC (MedAssets) contract for Cook County Health and Hospitals System (CCHHS) primarily at the facilities at John H. Stroger, Jr., Hospital, as well as through on site and remote inquiries off the staff and management of CCHHS, MedAssets, and Cook County.

Per our proposal dated January 19, 2008 and subsequent discussions with management and the CCHHS Audit Committee, our primary objective was to advise CCHHS as to the validity of the November 18, 2008 MedAssets invoice to CCHHS and also to include an evaluation of the services provided to CCHHS by MedAssets. Based on our arrangement letter dated February 15, 2009, we were to perform the following:

- Review and reperform the fees payable to MedAssets for June, July, and August 2008 per the provisions of the revenue cycle services contract dated May 20, 2008.
- Review and reperform the calculation of the November 18, 2008 contractor invoice and payment terms for June, July, and August 2008 per the provisions of the revenue cycle services contract
- Review and provide an analysis of progress-to-date against the Statements of Work (SOW) per the provisions of the revenue cycle services contract
- Provide observations in connection with our performance audit related to the MedAssets contract for revenue cycle services

We were not engaged to reperform or "re-base" the Annual Baseline revenue and benefit figures per the provisions of the revenue cycle services contract.

This report is intended solely for the information and use of management and the Audit Committee, and should not be used for any other purpose.

The attached report documents the processes, calculations, and analysis performed, as well as the results of our inquiries and observations performed on site. It also includes a list of general observations and recommendations as a result of our work.

Organizational Structure

It is our understanding that CCHHS is the third largest public hospital system in the United States operated by a unit of local government and is, by far, the largest provider of medical care to the uninsured, underinsured, and Medicaid populations in the state of Illinois. The emergency department at John H. Stroger, Jr., is one of the busiest in the metropolitan Chicago area with a 2006 census of more than 244,000 patient encounters; more than three times the next most active emergency department with a census of approximately 80,000. The Provident Hospital emergency department is the fourth largest in the area with almost 54,000 encounters in 2006.

Arrangement with MedAssets

It is our understanding that CCHHS engaged MedAssets on May 20, 2008 through the authorization of the Cook County Board of Commissioners. CCHHS has chosen to engage MedAssets to conduct an assessment, analysis, re-design, and implementation of processes related to the revenue cycle for inpatient and outpatient services. Under the provisions of the contract, MedAssets is also providing staff to CCHHS in order to accomplish various tasks in the patient financial services department.

Our Approach
RSM McGladrey completed certain procedures related to the MedAssets contract for revenue cycle services. We reviewed or performed the following:

- Contract for Revenue Cycle Re-engineering Revenue Cycle Services between Cook County on behalf of CCHHS and MedAssets
- MedAssets contractor invoice dated November 18, 2008
- Intergovernmental Agency Agreements between the Illinois Department of Healthcare and Family Services and CCHHS
- Medicare, Medicaid and SCHIP Benefit Improvement and Protection Act (BIPA) payment letter dated August 12, 2008 from the Illinois Department of Healthcare and Family Services
- Cash Report Summaries for John H. Stroger, Jr. Hospital, Oak Forest Hospital, and Provident Hospital for June, July, and August 2008
- Bank statement detail for John H. Stroger, Jr. Hospital (Stroger), Oak Forest Hospital (Oak Forest), and Provident Hospital (Provident) for June, July, and August 2008
- Bank statement detail on behalf of CCHHS provided by Cook County (primarily related to Medicaid/Public Aid patient cash receipts)
- Volume activity, by location, by patient type, by quarter, provided by Fred Zitlaw, Information Technology Contractor for CCHHS
- Various work outputs and presentations provided by MedAssets
- Interviews, among others, with the following individuals:
    - Pitt Calkin, CCHHS
    - Robert Wright, MedAssets
    - Gretchen Ryan, MedAssets
    - Paul Kania, CCHHS
    - Steve Kulhanek, CCHHS
    - George Lim, CCHHS
    - Mamerto Blancaflor, CCHHS
    - Fred Zitlaw, Contractor for CCHHS
    - Kelvin Magee, CCHHS
    - Robert Vais, CCHHS
    - Jimmie Williams, CCHHS
    - Albert De La Cruz, Med Assets
    - Mark Sabat, MedAssets
    - John Morales, Cook County
    - Shakeel Qureshi, Cook County

Overview of Our Approach and Findings
Our detailed approach, findings, and general observations and recommendations are described herein.

Conclusion
We were not engaged to and did not conduct an examination or review, the objective of which is the expression of opinion or limited assurance. Accordingly, we do not express such an opinion or limited assurance. Had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

Based on our procedures, we developed general observations and recommendations for improvement primarily as it relates to processes related to recording and documenting cash receipts related to clinical services rendered at CCHHS. Additionally, we have included in this report general observations and findings as it relates to the measurement of performance against the revenue cycle services contract. These items considered, the fees payable per the revenue cycle services contract and the invoice and payment terms appear appropriate and valid given the terms of the contract between Cook County on behalf of CCHHS and MedAssets.

2. OUR APPROACH

The procedures consisted of the following steps:

- Discussions with key representatives of CCHHS management and staff, representatives of MedAssets, and Cook County representatives, to gather and obtain information related to the revenue cycle services contract
- Obtain copies of the written agreements and invoices between CCHHS and MedAssets
- Gather and analyze the information provided by CCHHS to MedAssets to ensure adherence to the calculations and documentation defined per the revenue cycle services contract
- Weekly progress meetings with key representatives of CCHHS management and staff, CCHHS Audit Committee, and representatives of MedAssets to discuss engagement status as well as Annual Baseline and Monthly Baseline re-evaluation and re-basing
- Detailed RSM revenue and volume calculations for the months of June, July, and August 2008
- Interviews with MedAssets' management team and review of existing documentation prepared by or obtained by MedAssets related to the Statements of Work as defined in the revenue cycle services contract
- Conclude and provide general observations and recommendations in connection with our procedures related to the MedAssets contract for revenue cycle services
- Review of our findings with the Audit Committee at the March 12, 2009 Audit and Compliance Committee meeting

3. OUR FINDINGS

Fees Payable and Contractor Invoices and Payment Terms

Our approach as it related to the validity of the November 28, 2008 MedAssets invoice (fees payable and contractor invoice and payment terms) was to initially gather the source documents provided to MedAssets by CCHHS that were ultimately used to create and develop the invoice. We determined the documents used to create the invoice were the Cash Report Summaries for Stroger, Oak Forest, and Provident for June, July, and August 2008 prepared by CCHHS management and staff. Our objective was to trace Revenue from the Cash Report Summaries to source documents. Source documents, per review of the detail provided by CCHHS, were the bank statements of the above entities and the Intergovernmental Agency Agreements between the Illinois Department of Healthcare and Family Services and CCHHS.

We understand that "cash receipts" is defined by CCHHS as patient revenues and other operating revenues. Patient revenues are cash receipts derived directly from clinical services. Other operating revenues are derived from all other sources, non-clinically related.

Revenue as defined per the MedAssets contract is as follows:

Excerpt related to Revenue per the contract (Part III, Section 12) dated May 20, 2008

"Revenue" shall equal all patient related cash receipts received or posted by Contractor or the Bureau and includes all payments received by Bureau for all clinical services rendered less: 1) Settlements of Retro Receivables accounted for in non-patient receivables and cash accounts, typically due to or from third party payors; 2) Non patient related cash receipts received either through PIP or check, e.g. Medicare Bad Debt pass through payments; 3) Medicaid supplemental payments; and, 4) Intergovernmental Transfer Payments.

Based on our discussions with CCHHS management and staff we learned and performed the following:

- We obtained the June, July, and August 2008 Cash Report Summaries, as well as corresponding bank statements for Stroger, Oak Forest, and Provident from Jimmie Williams, Paul Kania, and George Lim of CCHHS
    - Per discussions with the above individuals, all cash (both patient related and other operating cash, or non-patient related cash) represented on the reports with the exception of Medicaid/Public Aid (these monies were received and deposited at the Cook County Comptroller's Office) were received and deposited in the bank accounts presented and discussed with the above individuals
    - We did not test for existence of cash not represented to us by CCHHS employees. In other words, we attempted to agree cash per the Cash Report Summaries to the bank statements provided and did not confirm existence of any other cash accounts or balances, if applicable
    - Bank statements were received directly from CCHHS and not received directly from the associated banks
- Patient related cash receipts as represented on the Cash Report Summaries were presented on the cash basis of accounting versus the accrual basis of accounting. Basis appears consistent with the terms of the revenue cycle services contract
- The majority of patient related cash receipts were Medicaid/Public Aid monies and these funds are received directly at the Cook County Comptroller's Office rather than CCHHS. As a result, we:
    - Reviewed the Intergovernmental Agency Agreements between the Illinois Department of Healthcare and Family Services and CCHHS dated June 3, 2008 (payable on June 10, 2008 via wire transfer), June 30, 2008 (payable on July 8, 2008 via wire transfer), and August 5, 2008 (payable on August 12, 2008 via wire transfer)
    - We agreed the above wire transfer activity, by month, to the bank statement retained at the Cook County Comptroller's Office

- We noted the Allocation of County Contribution Public Aid prepared by Robert Vais, CCHHS, agreed arithmetically, without exception, and ultimately agreed to the amounts, net, per the Intergovernmental Agency Agreements identified above
- Received documents directly from CCHHS and not received directly from the Illinois Department of Healthcare and Family Services

- RSM attempted to agree amounts per the Cash Report Summaries by facility to the corresponding bank statements and encountered difficulty agreeing amounts. Based on our discussions with management, discrepancies existed due to the following:
  - Bank statement detail was not available until several days after month-end
  - Electronic fund transfer (EFT) amounts available via online banking oftentimes did not clarify the payor, as a result discrepancies may have existed between actual and initial posted amounts on the Cash Report Summaries (e.g., EFT may not have differentiated between a transfer from Medicare or Blue Cross)
  - It appears Cash Report Summaries were not reconciled to the month-end bank statements to ensure completeness
- In order to gain comfort surrounding cash receipts by facility, RSM performed a calculation by performing the following:
  - From the bank statements provided by CCHHS and discussions with management and employees, we were able to classify cash receipts by facility by the Medicare and Other payor classifications
  - As noted above, cash receipts represented both patient related and non patient related receipts
  - RSM agreed and recalculated total deposits or cash receipts per the monthly bank statements without exception
  - Total cash receipts per the Cash Report Summaries (net of Medicaid/Public aid monies) should agree without material exception to total cash receipts per the corresponding bank statements

RSM calculations, by month, classified as Medicare and Other (including other operating) were as follows:

June 2008	Per Cash Report Summary	Per RSM Calculation	Difference
Stroger			
Medicare	$ 2,361,659.25	$ 2,013,621.96	$ 348,037.29
Other (including other operating)	1,393,519.39	1,748,607.93	(355,088.54)
Total Revenues (excluding Medicaid)	3,755,178.64	3,762,229.89	(7,051.25)
Provident			
Medicare	473,845.81	466,508.96	7,336.85
Other (including other operating)	407,277.81	408,279.87	(1,002.06)
Total Revenues (excluding Medicaid)	881,123.62	874,788.83	6,334.79
Oak Forest			
Medicare	307,437.00	324,364.00	(16,927.00)
Other (including other operating)	110,664.00	115,150.03	(4,486.03)
Total Revenues (excluding Medicaid)	418,101.00	439,514.03	(21,413.03)
Total for Month	$ 5,054,403.26	$ 5,076,532.75	$ (22,129.49)

July 2008	Per Cash Report Summary	Per RSM Calculation	Difference
Stroger			
Medicare	$ 4,894,730.75	$ 4,376,380.99	$ 518,349.76
Other (including other operating)	1,353,993.79	2,006,840.60	(652,846.81)
Total Revenues (excluding Medicaid)	6,248,724.54	6,383,221.59	(134,497.05)
Provident			
Medicare	807,886.71	807,886.71	-
Other (including other operating)	182,742.49	213,085.73	(30,343.24)
Total Revenues (excluding Medicaid)	990,629.20	1,020,972.44	(30,343.24)
Oak Forest			
Medicare	485,886.00	560,754.34	(74,868.34)
Other (including other operating)	81,001.00	85,323.41	(4,322.41)
Total Revenues (excluding Medicaid)	566,887.00	646,077.75	(79,190.75)
Total for Month	$ 7,806,240.74	$ 8,050,271.78	$ (244,031.04)

August 2008	Per Cash Report Summary	Per RSM Calculation	Difference
Stroger			
Medicare	$ 3,252,856.94	$ 3,195,615.85	$ 57,241.09
Other (including other operating)	1,518,661.07	1,913,329.01	(394,667.94)
Total Revenues (excluding Medicaid)	4,771,518.01	5,108,944.86	(337,426.85)
Provident			
Medicare	1,119,326.75	1,070,475.61	48,851.14
Other (including other operating)	269,057.62	250,332.59	18,725.03
	-	-	-
Total Revenues (excluding Medicaid)	1,388,384.37	1,320,808.20	67,576.17
Oak Forest			
Medicare	210,710.00	203,827.33	6,882.67
Other (including other operating)	46,756.00	45,307.85	1,448.15
Total Revenues (excluding Medicaid)	257,466.00	249,135.18	8,330.82
Total for Month	$ 6,417,368.38	$ 6,678,888.24	$ (261,519.86)
Total for Quarter	**$ 19,278,012.38**	**$ 19,805,692.77**	**$ (527,680.39)**

It could not be determined, with certainty, if the differences existed in the patient related or non patient related classification. We did not test the classification and deposit detail as presented by CCHHS, as this task would involve a significant amount of time and would entail agreeing amounts, as well as supporting documentation. On average, however, for these three months total cash receipts per RSM exceeded the amounts per the monthly Cash Report Summaries.

The next step of our approach as it related to fees payable and contractor invoice and payment terms was to recalculate the amounts included in the November 18, 2008 MedAssets contractor invoice. Based on our discussions with Mark Sabat, MedAssets, the documents used to create the invoice were the Cash Report Summaries for Stroger, Oak Forest, and Provident for June, July, and August 2008 prepared by CCHHS management and staff.

Excerpt related to the Contractor Invoices and Payment terms per the contract (Part III, Section 12)

Contractor Invoices and Payment Terms. Contractor shall issue monthly invoices for all Fees payable. All payments due from Bureau hereunder shall be due no later than sixty (60) days after receipt thereof. However, notwithstanding the foregoing, Contractor shall not remit any invoice until such time as five million dollars and no cents ($5,000,000.00) in Benefits have been achieved (the "Initial Invoice Threshold"). At such time, Contractor shall issue an invoice for two million five hundred thousand dollars and no cents ($2,500,000.00) which shall be due and payable pursuant to the payment terms set forth herein.

"Benefit" shall equal 1) the monthly Revenue (as defined above) less the Monthly Baseline

Based on the results of our calculations noted above, we could not confirm/deny the amounts that should be classified as patient related revenues. As a result, we recalculated and retraced the amounts per the Cash Report Summaries to the November 18, 2008 MedAssets contractor invoice. The results of our testing and findings were as follows:

- The Monthly Baseline figure was not reviewed or recalculated. Although $22,500,000 per month is the Baseline amount per the revenue cycle services contract, $22,300,000 was used as an amendment based on certain agreed-upon-procedures performed by an independent professional services firm. We did not test or recalculate this amount
- The differences noted above were not included in the "Per RSM Calculation" amounts listed below, only reclassifications between Medicare and Other were made as a result of our findings
- Amounts per the Med Assets invoice were arithmetically accurate and agreed to supporting calculations provided by MedAssets without exception
- Differences between the "Per MedAssets Invoice" and "Per RSM Calculation" were the followings:
    - Medicare difference was due to reclassification of "Per RSM Calculation" and "Per Cash Report Summary" between Medicare and Other. Reclassification netted to zero and did not impact total cash
    - Collection agency fees included within the Cash Report Summaries for Stroger were excluded from the Per RSM Calculation as these amounts were determined to be collected from other agencies, not MedAssets. Separating these amounts was based on our discussions with CCHHS and MedAssets, although specifically these amounts were not identified to be excluded per the revenue cycle services contract
    - Medicaid amounts by facility varied between the calculations provided by Steve Kulhanek, CCHHS and the amounts provided by Robert Vais, CCHHS. Differences netted to zero and did not impact total cash in the Medicaid payor category. Total Medicaid monies were agreed to the Intergovernmental Agency Agreements between the Illinois Department of Healthcare and Family Services and CCHHS dated June 3, 2008 (payable on June 10, 2008 via wire transfer), June 30, 2008 (payable on July 8, 2008 via wire transfer), and August 5, 2008 (payable on August 12, 2008 via wire transfer) as well as bank statement activity without exception

RSM calculations, by month, were as follows:

June 2008

Revenue by Payor CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Medicare	$ 2,919,222	$ 2,804,495	$ 114,727
Medicaid	17,869,171	17,869,171	(0)
Other	1,367,649	1,482,376	(114,727)
Total Patient Revenues	22,156,042	22,156,042	-
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ (143,958)	$ (143,958)	$ -

Revenue by Facility CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Stroger	$ 17,069,959	$ 17,077,118	$ (7,159)
Provident	2,999,487	2,557,137	442,350
Oak Forest	2,086,596	2,521,787	(435,191)
Total Patient Revenues	22,156,042	22,156,042	-
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ (143,958)	$ (143,958)	$ -

July 2008

Revenue by Payor CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Medicare	$ 6,188,503	$ 5,745,022	$ 443,481
Medicaid	15,684,209	15,684,209	0
Other	1,235,698	1,679,179	(443,481)
Total Patient Revenues	23,108,410	23,108,410	-
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ 808,410	$ 808,410	$ -

Revenue by Facility CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Stroger	$ 17,795,489	$ 17,799,118	$ (3,629)
Provident	3,011,538	2,741,411	270,127
Oak Forest	2,301,383	2,567,882	(266,499)
Total Patient Revenues	23,108,410	23,108,410	-
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ 808,410	$ 808,410	$ 0

August 2008

Revenue by Payor CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Medicare	$ 4,582,894	$ 4,469,919	$ 112,975
Medicaid	21,228,556	21,228,556	(0)
Other	1,000,878	1,113,853	(112,975)
Total Patient Revenues	26,812,328	26,812,328	-
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ 4,512,328	$ 4,512,328	$ -

Revenue by Facility CCHHS	Per Med Assets Invoice	Per RSM Calculation	Difference
Stroger	$ 19,825,228	$ 19,833,568	$ (8,340)
Provident	4,392,313	3,729,940	662,373
Oak Forest	2,594,787	3,248,820	(654,033)
Total Patient Revenues	26,812,328	26,812,328	0
Baseline	22,300,000	22,300,000	-
Cash Improvement	$ 4,512,328	$ 4,512,328	$ 0

Total for Quarter	**5,176,780**	**5,176,781**	**-**

Conclusion

As noted above, there was no difference between our calculation and the amount per the Med Assets invoice. However, the quarterly difference between our calculation and the amount per the Cash Report Summaries was ($527,680.39). It could not be determined, with certainty, if the differences existed in the patient related or non patient related classification. We did not test the classification and deposit detail as presented by CCHHS, as this task would involve a significant amount of time and would entail agreeing amounts, as well as supporting documentation. These items considered, the fees payable per the revenue cycle services contract and the invoice and payment terms appear appropriate given the terms of the contract between Cook County on behalf of CCHHS and MedAssets.

Volume

The final step of our approach is it related to the fees payable and contractor invoice and payment terms was to conclude on whether or not volume supporting the Baseline varied by more than five percent (5%) during the June, July, and August 2008 periods.

Excerpt related to Monthly Baseline per the contract (Part III, Section 12)

Contractor and the Bureau agree to re-evaluate (and potentially recalculate) the Annual Baseline and Monthly Baseline if either volume supporting the Baselines varies by more than five percent (5%) or the blended contract payment rate (from government, commercial insurance, or managed care payers) varies by more than five (5%) from the Effective Date of this Agreement.

The results of our testing and findings were as follows:

- As noted above, the Monthly Baseline figures were not reviewed or recalculated
- Volume information was provided by MedAssets and confirmed through our discussion with the creator of the volume reports, Fred Zitlaw, CCHHS Contractor
- Volume statistics reference were:
    - Inpatient – discharges
    - Outpatient – registrations
- We did not agree volume statistics to supporting documentation. Data provided by CCHHS were taken on face value and not agreed to source documents
- Volumes presented in the November 18, 2008 invoice were arithmetically accurate and recalculated without exception

Statements of Work

Finally, we performed interviews with MedAssets' management team and reviewed existing documentation prepared by or obtained by MedAssets related to the Statements of Work (SOW) as defined in the revenue cycle services contract.

Excerpt related to the Contractor Invoices and Payment terms per the contract (Part III, Section 12)

All invoices submitted by the Contractor shall be in accordance with the Fees provisions of this Section and shall be attached to a detailed description of the Deliverables provided by Contractor during the monthly period preceding the month in which payment is requested.

Our Assessment and Comments as they relate to the Deliverables per the contract are as follows:

RSM's Review Approach:

MedAssets began work on June 16, 2008 at CCHHS. This status and review is of March 4, 2009.

RSM McGladrey's review process was conducted via interviews with MedAssets management team (inquiry) and through review of existing documentation prepared by or obtained by MedAssets (reports, memoranda, flow charts, organization charts, project plans, etc.).

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Review and document initial patient flow when presenting for service. Assess and provide redesign recommendations, as necessary, to include flow, ability to capture each patient, and reconcile patients presented to patients seen. Use existing technology to extent possible. • **Resources:** Contractor will assign a resource to work with Bureau Finance personnel during the first week of the contract. • **Timing:** Estimated this will take 90 days.	• MedAssets presented to the CCHHS Finance Committee on 9/12/08 outlining recommendation to implement changes to Financial Counseling and Pre-Registration. • To support this recommendation the CCHHS Board subsequently approved a new organization structure which called for all Registration staff to report to the System CFO.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets performed a review and documented the present state inpatient access process flow within the first 90 days of the contract (beginning June 16, 2008). MedAssets also made recommendations for the future state of the Financial Counseling and Pre-Registration processes. These recommendations were documented in a PPT presentation (Finance Committee091208.PDF) on pages 10 – 18. This PPT was presented to the Finance Committee of the Board on September 12, 2008. The CCHHS Board was subsequently presented with and approved a new organizational structure which has all registration staff reporting to the CCHHS CFO rather than through Operations.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Review and document the physicians' process, for capturing charges and coding each encounter. • **Resources:** Contractor will dedicate the resources to review the work flow, SuperBill completion process by site, and use selected reporting to review coding, accuracy and charge capture performance by physician **within the first 60 days** of the contract. Based on the information gathered, a redesigned process will be created. It is expected that any changes in the current process will require extensive training for the physicians, including ongoing reporting and monitoring compliance. • **Timing:** Estimated this will take 150 days to complete with the initial focus on the larger volume clinics.	• The MedAssets Charge Capture team has compiled all of the charge capture tools used at the clinics. This book represents the core process for each physician to capture charges and coding of outpatient encounters. • The MedAssets Charge Capture team also reviewed/continues to review bill hold reports and provide coding support where required to properly capture missed charges and incomplete diagnoses. This is demonstrated by way of a July report detailing accounts that require additional work. • The MedAssets work plan outlines a very detailed process for each outpatient area to ensure charging and associated coding is completed electronically rather than on paper. • The primary focus for change has been around Surgical services, Radiation Therapy, Infusion, Dialysis, and high dollar Radiology.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that it has compiled a binder containing the charge capture tools at the System Clinics. The binder was shown to McGladrey as evidence of its existence. MedAssets indicated that the binder was completed in mid-August 2008 and that as of that date, MedAssets had its "arms around the problem" of charge capture and coding. MedAssets stated that the first Bill Hold report, used to quantify the number of bills not being released for payment was produced on July 21, 2008. This report summarizes charge types both by number and summed charges. McGladrey was provided with a copy of this report (strogerholds072108.pdf) which captures bill holds as of a point in time. MedAssets stated that this report is produced and worked each week to correct holds and release charges for payment. MedAssets also indicated that this is an interim report solution and that they are working on a Power Form fix in Cerner (permanent solution). **Recommendation:** McGladrey recommends that MedAssets modify this report from a "point in time" tool to a report that shows aging and changes from prior periods. MedAssets has a work plan in MS Project which details how providers in each outpatient area will transition from using paper to capture coding for charges to a fully electronic solution. McGladrey was shown this work plan as evidence of its existence. MedAssets stated that this work plan is updated weekly. The work plan focus on: Surgical Centers, Radiation Therapy, Infusion, Dialysis and High Dollar Radiology (**THE TOP FIVE**) areas of focus.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Contractor will evaluate the requirements to implement a centralized Pre-Registration/ Verification process for scheduled patients through one location. This would result in patients being registered, screened for eligibility, authorized, and pre-certified in advance of their visit or procedure. Uninsured patients could be flagged at the same time for case workers to interview prior to, or when they present for service to further screen for eligibility. This would also result in less wait time for service once the patient presents for service. • **Resources:** Contractor will assign its personnel to conduct this evaluation and will work closely with Bureau Management to determine feasibility and return on this effort. • **Timing:** This assessment will begin within the first 45 days.	• This item was part of the plan from the first day of this engagement. Initial conversations with David Small always included implementing this item. • This item was presented to the Finance Committee on September 12, 2008 for approval.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets began its evaluation of the requirements to implement a centralized Pre-Registration/Verification process for scheduled patients through one location in June 2008 and completed the evaluation in mid-August 2008. The outcome of this evaluation and recommendations were documented in a PPT presentation (Finance Committee091208.PDF). This PPT was presented to the Finance Committee of the Board on September 12, 2008. MedAssets developed Pre-Registration/Verification policies and procedures. While these Fiscal Policies and Procedures have not yet been approved by the Board, MedAssets have been given permission to proceed with the changes to the organizational direction as outlined in **Finance Committee091208.PDF**. MedAssets provided McGladrey with a copy of the policy procedures. MedAssets stated that the timing of the approval of the Fiscal Policies and Procedures will impact how and when the changes will be implemented.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Contractor will evaluate the financial, operational, and needs regarding the implementation of a Point of Service (POS) cash collection program for self pay, and co-pays. Contractor will develop a recommended financial policy to support collections efforts at time of service; including amounts, credit card machines/cash banks, reconciliation method, and scripts to be used by staff. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** This assessment will begin within the first 45 days.	• MedAssets considered this item as part of the initial plan from the beginning of the engagement. We developed policies and procedures that have been presented to the board and we continue to wait for approval since November 2008. • When MedAssets arrived the policy in place allowed the Pharmacy to collect co-payments. It has always been MedAssets intention to expand POS collections to all points of entry by way of a financial clearance policy paired with a revised Charity Care Policy.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that within 45 days of the contract, MedAssets had completed an evaluation of the financial, operational, and needs regarding the implementation of a Point of Service (POS) cash collection program for self pay, and co-pays. This evaluation was completed in July 2008. In addition, MedAssets stated that they had developed Policies and Procedures and presented them to the Board in November 2008 and are awaiting Board approval. MedAssets provided McGladrey with a copy of the policy procedures. MedAssets also indicated that the implementation of a POS cash collection program for self pays and co-pays would take time as its success was contingent on a culture shift within CCHHS and as such would be contingent upon a revised Charity Care Policy and Procedures.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Contractor will identify and recommend data quality and quantity goals for registration staff and management, including required reporting to monitor compliance. Contractor will work with Bureau management to construct a monthly audit of process. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** Within 90 days.	• MedAssets presented staffing to the Finance Committee in September 2008. This staffing was developed using volume data retrieved from the hospital information systems. • MedAssets is unable to implement across the board qualitative measures until policies and procedures are approved. This approval process is required in a Union environment.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that within 90 days of the contract, MedAssets had identified and recommended data quality and quantity goals for registration staff and management (including required reporting to monitoring compliance). MedAssets first focused on the quantity component of the assessment and presented a staffing plan to the Finance Committee of the Board in **Finance Committee091208.PDF** on September 12, 2008. Data for the quantity portion of the assessment was obtained from hospital information systems. MedAssets also indicated that they have developed a productivity model for patient registration, a staffing model and across the board policy and procedures for both the quality and quantity aspects of the registration process. MedAssets provided McGladrey with a copy of the productivity model, staffing model and policy procedures. The implementation of these policies and procedures are on hold awaiting approval of the Union.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Contractor will review and evaluate the on-line eligibility tools currently used by Bureau at time of registration and in Patient Financial Services. Contractor will make a recommendation as to their effectiveness and value and identify alternative if necessary. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 30 days	• MedAssets met with Nebo to review the online eligibility tool in use at Stroger and Oak Forest Hospitals on June 18, 2008 at 2PM. The results of this meeting indicated the tool was adequate for the needs of the System. We supported and initiated where required further training by Nebo for county staff. • Provident Hospital uses HDX rather than Nebo. MedAssets did not review this tool because we were informed that Provident was moving to Cerner Registration in the very short term and with that would move Nebo would be implemented.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that within three days of arrival on-site at CCHHS, MedAssets had reviewed and evaluated the on-line eligibility tools currently used by Bureau at time of registration and in Patient Financial Services.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 2	Contractor will review and document the current uninsured patient review process to develop effective eligibility processes, including both Bureau staff involved in this process, as well as, outside vendors used. Contractor will develop a process improvement plan to be submitted to Bureau Chief Operating Officer. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 30 days.	• MedAssets met with Eligibility vendors as follows: ○ HRM – June 19, 2008 at 1PM ○ CEA – June 19, 2008 at 8am ○ ESI – June 19, 2008 at 1PM ○ Great Lakes – June 17, 2008 at 1PM	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that the uninsured patient population at CCHHS is managed by four vendors. MedAssets stated that as a result of the interviews with the four vendors a recommendation was proposed to the Finance Committee of the Board in **Finance Committee091208.PDF** on September 12, 2008. This recommendation was to go to a full outsourcing solution with one vendor. Based on our discussions and review of supporting documentation, the interviews and corresponding dates were as follows: ○ HRM – June 19, 2008 at 1PM ○ CEA – June 19, 2008 at 8am ○ ESI – June 19, 2008 at 1PM ○ Great Lakes – June 17, 2008) The recommendation received Board approval, but implementation is on hold due to vendor contracting issues and space for vendor personnel.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 3	Contractor will evaluate the financial, operational and needs regarding the development of a central business office for one or more Bureau Operating Units. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** This effort will begin day 1 of the project.	• MedAssets was informed in the initial discussions with David Small that he wanted to house the CBO at the Oak Forest location. It was MedAssets intention from the beginning of this engagement to implement a CBO. We are currently working with facility personnel to prepare the identified space for staff to move in to.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets began its evaluation the financial, operational and needs regarding the development of a central business office for one or more Bureau Operating Units on day 1 of the project.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 3	Contractor will conduct a review of the current billing process including claims preparation, edits, electronic tools used, staffing, and reporting. Contractor will recommend and develop a set of daily and monthly reports to monitor billing errors by type and location. This information will be used in training and to request system edits. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** Immediately after start date	• MedAssets implemented augmented staff in July 2008 responsible for billing and follow-up activity using the SMS system.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that immediately after the contract start date, MedAssets conducted a review of the current billing process including claims preparation, edits, electronic tools used, staffing, and reporting. Subsequent to this review MedAssets developed the Stroger Holds Report (**strogerholds072108.pdf**) for outpatient bills and a Discharged Not Final Billed (DNFB) report for inpatient claims. MedAssets stated that County staff works the more current bills, MedAssets work bills over 90 days old through MedAssets Summit software and that Self Pay bills go to a collection agency.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 3	Contractor will prepare an analysis of the current Accounts Receivable and will identify inventory that has timed out and cannot be collected. Contractor shall make recommendations regarding the disposition of these accounts, i.e. write offs, etc.... Contractor will prioritize existing A/R to allow follow-up based on aging and dollar amount. Further, Contractor may recommend the creation of government and non-government follow-up teams to allow for more focused follow-up. • **Resource:** Contractor will prepare this analysis. • **Timing:** First 30 days	• MedAssets augmented staff has been working accounts since July 2008. As part of that process the staff follows county policy on requesting account adjustments and write-off recommendations. • MedAssets has identified accounts with the highest probability of payment success in our Summit workflow application and our augmented staff is working accounts from that system. • A recent policy change will allow the System to better monitor write off processes.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that within 30 days of the contract date, MedAssets prepared an analysis of the current Accounts Receivable and identified inventory that has timed out and cannot be collected. As a result of this analysis MedAssets recommended and had approved (in December 2008) a policy change that will allow CCHHS staff to better monitor (on a monthly basis) the write off process. This recommendation also targeted accounts past due by > 90 days versus 180 days. The process change is currently in the IT shake-out process and is expected to be implemented by the end of the second calendar quarter of 2009. MedAssets also stated that an organizational structure to create government claim and non-government claim follow-up units was approved by the board in December 2008.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 3	Contractor will design, by functional area within PFS, quality and quantity measures. Goals will be established along with reporting to monitor results. • **Resource:** Contractor will design this process. • **Timing:** Within 90 days	• MedAssets has developed a staffing analysis that is based on volumes data. Once MedAssets is able to get through the current Policy and Procedure approval process for previously submitted items, we will then present new Patient Accounting policies for approval. Until this is complete we will be unable to hold staff accountable to these goals since the Union will require notification.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets did not meet the 90 day timeframe for this Assessment item. MedAssets completed designing, by functional area within PFS, a staffing analysis (based on volumes data in the hospital Information Systems) for Patient Accounting in December 2008. Since the quality measures for Patient Accounting need Union approval and since approval of the Patient Registration Policies and Procedures are a dependency for this assessment item (**see Phase 1 #2**), MedAssets is pending submission of Patient Accounting Policy and Procedures for Board approval until the Patient Registration Policies and Procedures are approved. Prior to Board approval of the new Policies and Procedures MedAssets continues to work on day to day process improvements as appropriate.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 3	Contractor will perform an assessment of the current payer contracts related to reimbursement and make recommendations. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** Within the first 90 days.	• MedAssets requested and received copies of all available contracts. We performed a cursory analysis of the contracts. We were informed by David Small that Pitt Calkin would be responsible for negotiating new contracts so we have tabled this item until instructed otherwise.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets had, within the first 90 days of the contract, identified, located and performed a cursory review of the current payer contracts with respect to reimbursement. MedAssets provided McGladrey with a copy of a list of the contracts. This listing is dated July 15, 2008. (**contractmatrixCOOKCOUNTY.pdf**)

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 4	Contractor will recommend reasonable goals for inpatient and outpatient 'bill hold' days. Contractor will recommend standard daily reports required, by Hub, and identify and plan for operational use in conjunction with IT to monitor compliance. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• Bill hold days were reviewing in the first 30 days of the engagement. MedAssets made an initial determination that the current inpatient hold days of 5 should remain. Our best practice recommendation for this facility was delivered in the HIM report at 4. This report was presented to the Executive Revenue Cycle group in December 2008. • MedAssets continues to hold on making any significant changes to outpatient bill hold days due to pending operational improvements.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets conducted a review of Bill Hold Days within the 30 days of the beginning of the contract. MedAssets determined that operational improvements (electronic encounter submissions versus paper) and system interface changes needed to be addressed before this Assessment item could move forward. MedAssets completed a HIM Assessment Report on November 11, 2008 related to this Assessment item that was presented to the Executive Revenue Cycle Committee in December 2008. MedAssets showed the HIM Assessment Report to McGladrey as evidence of its existence.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 4	Contractor will review the clinical documentation process, work flow, staffing, and production, for each Hub's HIM/ Medical Records department and compare to applicable industry norms. If deficiencies are noted Contractor will document and identify in process improvement plans and assist Bureau Finance Bureau Personnel in implementation. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• HIM assessment was presented in December 2008	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets did not complete this Assessment item until December 2008 and thus was not in compliance with the contract. MedAssets indicated that the HIM Assessment Report was completed for three facilities on November 11, 2008 and present to the Executive Revenue Cycle Committee in December 2008. MedAssets indicated that they subcontracted with PDN (Professional Dynamic Network, Inc.) to complete this Assessment item.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 4	Contractor will conduct a clinical billing review of "observation" patients from the prior 12 months of Medicare and Medicaid accounts to determine if coding was appropriate, or if accounts can meet the inpatient criteria and can be reclassified for a higher reimbursement rate and recommend a course of action. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• HIM assessment was presented in December 2008	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets assigned personnel to this Assessment item within three days of the contract start date. MedAssets indicated that they determined that the tracking of OP Status at CCHHS was a problem for many reasons. MedAssets indicated that their findings and recommendations are related to "observation" patients are included in the HIM report completed on November 19, 2008 and presented to the Executive Revenue Cycle Committee in December 2008. MedAssets indicated that they will be performing a coding audit which will include "observation" patients.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 5	Assess the use of the Patient Accounting systems (including Siemens and Cerner), and other business office software used by the Bureau. Assessment will include a review of the major processes that feed the system, including registration, charge capture, eligibility, coding and will document any gaps or issues as they Revenue cycle operations. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• MedAssets was informed of 160 active interfaces at the Hospital System. MedAssets implemented Revenue Cycle Sub-Committees to address operation issues that result in improper data mappings and results in the SMS system.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that this Assessment item is being addressed by the following Revenue Cycle sub-committees: • Patient Access and Financial Counseling • Charge Capture (Clinical/CDM) • Patient Accounting • Health Information Management (HIM) This process is complicated by the fact that CCHHS has received approval to purchase and implement a new General Ledger System. CCHHS is currently in the process of sending out RFPs. No Go-Live date has been established.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 5	Identify changes that need to be made to minimize billing rejections, including a review of interfaces feeding the patient financial systems. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 30 days	• With over 160 interfaces, MedAssets determined the best course of action for this item is to use Revenue Cycle Sub-Committees to address operational issues/processes that will ultimately include gap analysis and resolution.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets began working on this Assessment item within 30 days of the contract start date. MedAssets indicated that they will be using the Revenue Cycle sub-committees to drive this Assessment item forward.

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 5	Investigate and assess the effectiveness of additional systems that are or may be used to optimize the billing and collection workflows, patient authorization and verification processes, and to integrate information received from each with the originating systems. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• MedAssets implemented Summit Patient Accounting work flow application for use by the augmented staff. This item is a stop gap measure until we prioritize the implementation of SMS Collector Workstation. • MedAssets is in the process of implementing Access Direct for the Patient Access workflow implementation.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that MedAssets, within the first 60 days of the contract, completed an investigation and assessment of the effectiveness of additional systems that are or may be used to optimize the billing and collection workflows, patient authorization and verification processes, and to integrate information received from each with the originating systems. MedAssets indicated that before they could move forward in October/November 2008 with the implementation of their proprietary software Access Direct for Patient Access workflow they needed to get approval of the Board (thus delaying implementation).

SOW Reference #	Assessment	Status	RSM McGladrey Comments
Phase 1 # 5	To evaluate the availability and use of data to optimally support business office operations. • **Resource:** Contractor will assign its personnel to conduct this evaluation working with Bureau Finance Personnel. • **Timing:** First 60 days	• MedAssets was able to review reports using Vista (hospital data repository). This access was available within the first 60 days and was ultimately modified to include a view of all users once we discovered there was no singular methodology. Specifically, each user has their own set of reports so in order to get a picture of reporting tools we needed to see everyone in the database.	McGladrey confirmed via a meeting/interview with Gretchen Ryan and Albert De La Cruz (MedAssets) on March 4, 2009 that this Assessment item was completed within the first 60 days of the contract.

Conclusion

As noted above, we performed interviews with MedAssets' management team and reviewed existing documentation prepared by or obtained by MedAssets related to the Statements of Work (SOW) as defined in the revenue cycle services contract. Based on our assessment and comments, it appears MedAssets is generally adhering to the deliverables and SOW's required per the contract .

4. GENERAL OBSERVATIONS AND RECOMMENDATIONS

In connection with the procedures performed related to our performance audit, we identified general observations and recommendations. These general observations and recommendations are intended solely as informational and should be used only by management, and should not be used or shared with any other parties.

Our comments are as follows:

Difficulty in Segregating Specific Revenue Streams

- Benefit as defined by the contract is monthly Revenue (as defined in this report) less the Monthly baseline. Per the contract:

  Excerpt related to the Calculation and Audit of Annual Baseline Revenue and Benefit Figures (Part III, Section 12)

  Such records and computations shall segregate specific revenue streams in both the Baseline calculations and the Benefits calculation, thereby facilitating audit activities and permitting the County

  - Based on our analysis and review of information provided as part of this engagement, we did not and could not segregate specific revenue streams in both the Baseline calculations and the Benefits calculation.

Cash Receipts Reconciliation

- Per discussions with CCHHS employees, the Cash Report Summaries are reconciled monthly to the bank statements.
  - Based on our analysis and review of information provided as part of this performance audit, we could not reconcile the detail on the Cash Report Summaries to the monthly bank statements without exception
    - We recommend the Cash Report Summaries be reconciled monthly to the bank statements. Additionally, we recommend the Medicaid/Public Aid amounts per the Intergovernmental Agency Agreements be reconciled to the bank statement detail held on behalf of CCHHS at the Cook County Comptroller's Office monthly.
    - We recommend preparation, consolidation, and review of a Consolidated Cash Report Summary for CCHHS. We recommend one individual be identified to prepare the summary and a separate individual to review the prepared monthly reports for accuracy. Amounts per the Summary should agree to bank statement activity without exception.
    - We recommend including MedAssets as part of this process to ensure and understanding and approval of the process and deliverables
    - We recommend that CCHHS immediately investigate and resolve the differences noted between the amounts Per Cash Report Summary and amounts Per RSM Calculation as noted in this report

Monthly Baseline Re-evaluation and Recalculation

- Per the contract, the Annual Baseline and Monthly Baseline will be re-evaluated (and potentially recalculated) if either volume supporting the Baselines varies by more than five percent (5%) or the blended contract payment rate (from government, commercial insurance, or managed care payers) varies by more than five (5%) from the Effective Date of this Agreement
    - Based on our analysis and review of information provided as part of this engagement, we recommend an amendment to the contract detailing and defining both items related to the blended contract payment rate and volume

Remittance Advice Reconciliations

- Based on our discussions with management, the monthly Medicaid/Public Aid amounts are agreed to the NEBO claims reports, as well as the Intergovernmental Agency Agreements between the Illinois Department of Healthcare and Family Services and CCHHS
    - Based on our analysis and review of the information provided as part of this engagement, we recommend agreeing the monthly remittance advice detail to the actual cash payment posted for Medicaid and Medicare

Cash Payments and Cash Receipts Related to Other Service Providers

- Based on our discussions with MedAssets and CCHHS management and employees, there exist additional vendors (eligibility, bad debt agencies, collection agencies, etc) that provide services outside of the MedAssets contract
    - Based on our analysis and review of information provided as part of this performance audit, we recommend an understanding be reached between CCHHS and MedAssets as to how the receipt and payments to these service provides are included/excluded as part of the contract

Medicare Recovery Audit Contractor (RAC) Program

- The Medicare RAC Program will be implemented in Illinois later this year. Most large health systems have begun to prepare for this program by performing specific internal procedures to identify possible loss contingencies and develop procedures to manage RAC requests for medical records
    - We recommend that CCHHS form a task force to address this new program in the near future

ATTACHMENT #2

CURRENT-YEAR SIGNIFICANT DEFICIENCIES, CONTROL DEFICIENCIES, AND OTHER MATTERS
Gook County Health Facilities Fund Year Ended November 30, 2007

I. STAFFING

Observation - Significant Deficiency - Certain employees were unable to prepare or review account reconciliations, analyze and evaluate information impacting the financial statements, and prepare complete interim financial statement information, among other financial reporting tasks. The main cause for the inability to perform these, responsibilities was due to inadequate staffing. It Was further noted that several key Hospital employees will be retiring within the next several years, and there is no formal succession plan to help identify replacements. In addition, a number of employees were transferred to new positions at other CCHF facilities or various County departments, leaving vacancies in critical roles at CCHF. Finally, certain of the key staff at the CCHF are actually filled by outsourced positions, leaving greater risk of the loss of knowledge of the entity and its processes and systems if these contracts are not renewed. Without appropriate staffing and succession planning, the existing employees will not be able to complete the necessary tasks effectively and in a timely manner.

Recommendation - Perform a needs assessment of the CCHF Finance Department resources across all locations to evaluate skill sets and responsibilities of the current employees to determine where additional staff is needed. Hire additional qualified staff in the Finance Department to enable CCHF to perform its financial reporting responsibilities efficiently and in a timely manner. Consider succession planning, as there are several key employees retiring in less than three years. Also re-evaluate which positions are outsourced and consider if this is the best option for the CCHF given the need to renew/renegotiate these contracts. Further, hire additional qualified staff for the Reimbursement Department as currently there is . only one individual at Stroger and one at Oak Forest, the former whom will be retiring within three years. As qualified staffing in -the Reimbursement Department is critical to .the. CCHF receiving proper reimbursement from Medicare, Medicaid, and Blue Cross, this function needs to be expanded to ensure experienced individuals are in place to ensure compliance with applicable regulations and to maximize receipt of the Health System's earned revenue.

Management Response -- Key staff members function in consulting roles. We have aggressively moved toward filling key positions at each facility. Some facilities have key positions outsourced and our County employees collaborate with these individuals in making decisions that impact the hospital system, thereby mitigating any loss of knowledge. We have also created a fiscal organizational chart.

Status of Recommendation: Senior management is currently updating all job descriptions and reviewing resumes and skills of existing staff in order to match the right skills with the job requirements. Also we are reviewing open employment needs and seeking to hire qualified candidates. This is an on-going process and a process that is continually being refined based upon operating needs, therefore there is no exact target date when this recommendation will be completely accomplished.

II. REVENUE AND ACCOUNTS RECEIVABLE

Observation .-- Significant Deficiency - Currently, the CCHF must obtain Board approval to write off uncollectible accounts. receivable, which has historically been done for one fiscal year at a time, approximately two years after charges are deemed uncollectible. In the current year, there were actually three years of uncollectible accounts receivable remaining in the accounts receivable detail trial balance. As a result of this excessive volume of accounts, the accounts receivable system, SMS, is unable to produce a detailed trial balance by patient account, as well as other detailed accounts receivable reports. Management should be analyzing these types of reports on a regular basis to view the receivable balances and make decisions on the adequacy of reserves; this analysis cannot occur- with the level of patient accounts currently in the system.

We also noted that management calculates the required allowance for doubtful accounts by applying an. estimated collection percentage, to the accounts receivable balances by aging category. for, each payor, which should be based on historical cash receipts, adjustments, and write-offs. for that payor. The . percentages were not updated in fiscal year 2007 and are based on the collections analysis performed in fiscal year 2006 on fiscal year 2005 accounts receivable. As the ultimate resolution of the fiscal year 2005 accounts receivable may not be -comparable to that of fiscal year 2007 accounts receivable, management needs to evaluate these percentages on a regular basis and, at a minimum, annually, based on current data.

We noted that each of the three Hospitals essentially operates on a stand-alone basis, preparing individual financial statements and creating separate accounting analyses and account reconciliations. Each entity has its own general ledger with varying charts of accounts. As a result, we noted inconsistencies in the . calculation of certain account balances and accounting estimates.'. We, also noted certain errors at some of: the entities.'" to these separate procedures. Further, we believe that management could better and more effectively evaluate the analyses at each entity if data were prepared consistently.

Additionally, while each of the entities utilizes the Siemens system, the systems were initially set up separately, resulting in different profiles and differing insurance codes and billing/collections parameters. This results in differences in the recording of accounts receivable and revenue in the general ledger.

Recommendation.-- Management should request that Board-approved write-offs occur more. frequently, such as on a quarterly basis. We did note that during the year the Information Technology department was focused on "scrubbing" the *accounts receivable detail so that only valid, collectible accounts were included. This effort should be continued to ensure that only valid accounts receivable are included in the detail. Management needs to be able to run detail accounts receivable reports by aging and payor on a monthly basis to reconcile to the general ledger and analyze the adequacy of the reserves.

To better estimate the allowance for doubtful accounts, perform a detailed analysis of accounts receivable collection experience by payor to validate the contractual allowance and bad debt percentages used to , *determine* the net realizability of the accounts. To this end, perform the following:

Utilize a zero balance report to determine ultimate collection, adjustment; or write-off experience to determine at what point these accounts are collected or written off.

- By payor, determine the percent of account balances that are written off at each aging category. Again, by payor, use these percentages to calculate the current-year. allowance for doubtful accounts needed for the accounts receivable balance.

  Update this analysis at least annually to ensure that the percentages used remain current.

Charge the newly hired Health System Chief Financial Officer with performing an assessment to identify areas where the various Hospitals are not performing consistent analyses/procedures. Standardized processes should be implemented to facilitate consistent analyses, management review, and decision making. Specific areas to consider include:

1. Recording of Intergovernmental Transfer payments and receipts on a gross basis versus a net basis in the general ledger.
2. Recording of undesignated revenue recognition reserves for open cost report years.

3. **Utilizing** of historical cash collections and zero balance analysis to determine actual net realization by

payor and type of service. This information should be used to set and update contractual allowance and bad debt estimates.

4. Recording of contractual allowances on billed Medicare accounts 'receivabl,e: :
5. Implementing of consistent parameters within the Siemens systems to standardize how the Hospitals generate and record revenues

Management Response - We concur with the recommendation. We are moving forward and expect to have a **policy** to present to the Cook County Health and Hospitals System Board by the end of fiscal year 2008 for approval: In addition, management is working with Med Assets to assist us in developing the policies to follow best practices consistently across the system. Some standardization of analysis and management review in decision making has occurred in fiscal year 2008.

Status of Recommendation: In November, 2008 we requested and received authorization from the Hospital Systems Board for current write-off of receivables. We are designing policies and procedures to better estimate allowance for doubtful accounts, analysis of accounts receivables, standardization processes so that each facility is consistent in analysis, review and decision making. We expect to have a first draft completed of policies and procedures by the end of January, 2009 with approval by the Systems Board by the end of February, 2009. As stated in our response, some standardization of analysis and management review in decision making has occurred in fiscal year 2008

III. BLUE CROSS PAYMENTS

Observation - ***Significant*** Deficiency - The CCHF receives advances from Blue Cross under the , Uniform Paynieat'Plan (iJPP)to standardize cash flow. The UPP payments are.not correlated to-the vouchers 'thaf the individual Hospitals receive; they are based on expected volume and reimbursement assumptions, and can be adjusted from time to time by Blue Cross. The Hospitals send claims to Blue Cross. Blue Cross processes the claim (usually within 1 to 2 months after receipt) and sends the Hospitals a voucher indicating that the claim has been approved/adjudicated, at which point the gross charges approved are applied against the advances received by the Hospitals through Blue Cross. At the same time, the contractual amount (gross charges less the contracted reimbursement' rate) is computed by Blue Cross and subtracted from future UPP payments (during the second month after the claim is adjudicated). The Hospitals receive notification of the contractual reduction that will be "taken back" by Blue Cross on a month-end report sent by Blue Cross. As such, a reconciliation of the Blue Cross, experience reports is necessary to property determine the amount of overpayment by Blue, Cross at year=end. In addition, for those Blue Cross accounts still recorded in accounts receivable, a contractual allowance against the receivable should be recorded to ensure the accounts are reported at the net realizable value.

Recommendation. Re-evaluate the methodology used to calculate the Blue Cross liability to ensure that the current activity is appropriately reflected. Use the Blue Cross experience reports dated November 30 and December 31 to reconcile the Blue Cross liability required for the amount of contractual allowances that Blue Cross has not yet taken back as of year-end.- Use the Blue Cross UPP _ . statement:dated~Novr,mber30,;taking into consideration any UPP deposits in transit or claims not yet processed by the Hospitals to determine the liability due to Blue Cross for amounts of cash overpaid to the CCHF. Additionally based on the contract terms with Blue Cross, calculate a contractual allowance for those Blue Cross patient. accounts still in accounts receivable. Finally, record the Blue Cross UPP liability within accounts receivable, rather than as other receivables, as this liability is directly related to patient accounts. : v

Management Response - The CCHHS management concurs with the recommendation even though Blue Cross is not a material part of our business. The System will, as part of its plans to improve interim financial .reporting; esaablish a process to;estimate Blue Cross net revenue. Cbarges:for services provided to Blue Gro~ss.subscribers'will'be prepared on a monthly basis. :A separate account will'be established to record the liability for Blue Cross UPP payments. Management agrees that the liability for UPP payments needs to be reconciled on a regular basis. The reconciliation process will ensure the facilities are being paid according to the terms of the contract and will allow the System to refine its monthly estimate of Blue Cross' contractual adjustments. This will be completed by the end of the second quarter of fiscal 2009.

Status of recommendation: We have corrected the methodology used to calculate the Blue Cross liability and this recommendation will not be repeated for fiscal year 2008

IV. CAPITAL ASSETS

Observation - Significant Deficiency -- During our audit, we identified a significant error in that $9.1M of construction in progress was double-counted in the CCHF and the County financial statements. This error was corrected on the CCHF financial statements. In addition, we noted that while items not meeting the capitalization threshold were, being expensed over a 12 – month period, not all items were fully expensed by year-end.

Recommendation -- Implement quarterly meetings between the Bureau of Finance and the Health Bureau to discuss the recording. of fixed assets, including construction in progress. Ensure that assets not meeting the capitalization threshold are completely expensed in the year of acquisition.

Management Response - While this has been a long-standing issue, we concur with the recommendation, and as part of developing our policies and procedures by the end of the second quarter of fiscal.year 2004, these issues will be, addressed.

Status of recommendation: We have developed monthly financial reporting and we meet monthly with County to discuss relevant financial issues, starting in fiscal year 2008. The recommendation regarding the improper recording of construction in process has been corrected and will not be repeated for fiscal year 2008.

V. INTERNAL AUDIT

Observation - Control Deficiency - While the County has its own Internal Audit department, there is currently no such centralized function for the CCHF. Due to the complexities and risks at each of the Hospital locations, an Internal Audit function would be instrumental in evaluating risks and developing action plans to address these risks at each entity. In addition, an Internal Audit function could provide much-needed communication to the new Health Board and senior management of both the CCHF and the County about the operations and internal controls processes on a more timely basis than relying solely on the external audit results.

Recommendation -Create a centralized Internal Audit function, led by a qualified, experienced internal audit professional and adequately staffed, to perform ongoing risk assessments, monitoring of internal controls, and testing of accounting and financial reporting practices at the Health System entities. Internal Audit should conduct a comprehensive risk assessment for the Health System as a whole and develop an audit plan to address these risks. Ensure that the Internal Audit function is given the ability to report directly to the new Health Board to be able to openly report findings and provide suggestions.

Management Response .~ We concur with the recommendation and we are moving forward with all due speed in conjunction with the audit committee to create the internal audit function.

Status of Recommendation: We currently have identified a consultant we will contract with to aid in our development of the internal audit function. We will be discussing the status of this development on an on-going basis with the Hospital Systems Audit Committee.

VI. CASH RECCNCILIATIONS

Observation --- Control Deficiency - Cash reconciliations were not prepared for all bank accounts on a monthly basis, which is an important detective control activity over cash. In addition, certain of the bank reconciliations that were prepared did not reconcile to the general ledger balances, as they included unreconciled items:-While none of these. items were individually or collectively material,, and we noted no instances of improprieties, the possible risk Of misappropriation of assets may not be detected without the completion of these reconciliations. In addition, there were not preparer or reviewer sign-offs on the bank reconciliations as evidence of timely review by independent employee.

Recommendation - Cash reconciliations should have a preparer and reviewer sign-off as evidence of preparation and timely review by an independent employee. Bank reconciliations should be prepared for all cash accounts on a monthly basis and should reconcile to the general ledger balances.

Management Response ,- We concur with the recommendation and the fiscal team will accomplish this goal by the end of fiscal year 2008 for appropriate reconciliation, review, and sign-off.

Status of recommendation: During fiscal year 2008 we have complied with this recommendation. We successfully completed the 2008 fiscal year-end interim testing with Deloitte and no issues on our part were unresolved or found deficient.

VII. REVIEW OF JOURNA L **ENTRIES.** ~...

not occur

Observadon'- Control Deficiency - Supervisory review of the journal entries did not occur consistently ,and was not always performed in a timely manner. We believe that a timely supervisory review could reduce potential errors and would help ensure proper segregation of duties in the financial reporting area.. . :

Recommendation - Review the current process over journal entry posting to ensure that proper segregation of duties is achieved. Ensure that all entries have a separate preparer and approyer. Sign off as evidence of this se~cegation. of duties and timely review.

Management Response -- We concur with the recommendation. We now have the appropriate fiscal management team in place to address staffing and other issues. The policies and procedures will identify those journal entries that require second level review. The policies and procedures will be completed by the end of the second quarter of fiscal year 2009.

Status of recommendation: During fiscal year 2008 we have complied with this recommendation. We successfully completed the 2008 fiscal year-end interim testing with Deloitte and no issues or deficiencies were found in this area.

VIII. INFORMATION TECHNOLOGY

Observation=- Control Deficiency -- Information security is critical to ensure that. unauthorized or inappropriate 4ccessaa the system does not occur, as this could negatively impact the.-financial. Statements. During the audit we noted a 'need for a centralized security policy among the hospitals and stronger password security. We also noted the lack of reviews of access to the system access performed on a regular basis.

Recommeudation - The CCHF should formalize a centralized security policy and standardize security procedures implementation. Procedures include:

A: `Implement stronger security parameters by enforcing password complexity.rules; periodic

. password expiry 60-90 days), enabling password history, and, increasing the lockout reset policy at the network level 'and at the application level, where applicable. Privileged accounts should not have an automatic lockout reset.

B. Perform user access reviews on a periodic basis to ensure only authorized individuals have active accounts on Active Directory/Novell environments.

C. Perform periodic security event reviews to ensure only authorized individuals are logging on to the'system.

D. Ensure that Human Resources or other management communicates to the applicatiois/systems administrator in a timely manner to ensure that users are removed from the system and procedures are followed Perform periodic user access reviews at the application level to ensure that unauthorized users'are removed from the application in a timely manner.

E. Document that security monitoring is being performed, management should sign off on any reviews.

Management Response',=-- The access control policy has been revised to .include the following requirements.:"A networkpassword must include at least 3 of the 4 following components: an uppercase letter, a lowercase letter, a number, and/or a special character. In addition, the password must be at least 8 characters and expire every 90 days. Where possible, all applications, passwords, e.g., (SMS, Cerner) will have the same requirements, Within the next six months, the Information Technology (IT) department will implement a single sign-on solution for the CCHHS community that will tie the network password to the application password, thus increasing overall security. We have started a limited rollout of the single sign-on for a few select departments at Stroger and Oak Forest hospitals. , , Referencaa$.~oint-$,.G; and'.D,for user access reviews and security event.rwiews; the IT Department is purchasing ,a-suite :of security'products with the capability for tracking user.access.from- initial network sign-on to sign-off. These products will tell us who has signed on, when that person last signed on, and show access rights to various applications. These products will be installed within the next six months. The reports generated from these products will be sent to the various H/R Departments and the user departments for further review and action.

Evidence of compliance will be provided by the reports generated by the security products and distribution to the appropriate parties.

Status of recommendation:

- ***A. D&T recommended changes were implemented. Access control policy was changed from 30 minutes to 5 minutes. Because of technical limitations with Novell software, AD group policy was revised to lock out users after 3 failed attempts.***
- ***B. OAFFICER group was reviewed and above names were deleted. Access to this group is now restricted to the IT security group, Siemèns personnel, and key IT personnel, on a need to-have basis.***
- ***C. It appears this responsibility falls on the user community. In the future. IT will provide periodic reports to the user and H/R communities at each facility to the facilitate tracking on all employees who have access to INVISION. The user community must determine if the level of access is appropriate.***
- ***D. We are in the process of implementing security products that will provide an end to end information security infrastructure to monitor user access and provide reports on a periodic basis.***
- ***E. This appears to be a timing issue. The names you submitted were either terminated from the system and/or are still active employees. Since we do not have real-time access to H/R data, we will always have a variance between H/R data and our access control lists. We are working with the H/R departments to improve communications and our new security products will go a long way in reconciling the difference.***

DL PHYSICAL INVENTORY

Observation -- Other - During the audit, we noted that the staff conducting the physical inventory observation at Provident did not have formal processes documented to follow during the count. In addition, in one particular instance, we noted that after the physical inventory. count was complete, the inventory system had not been properly updated.

Recommendation - Document formal processes related to the performance of physical inventory test counts. Update the inventory system after every physical inventory. test count to ensure that the, periodic counts of quantities on hand are reflected as updated in the system. .

Management Response - Management will review the current policy to ensure that it is applied consistently at all locations within the system. This will be applied by the end of fiscal year 2008.

Status of recommendation: During fiscal year 2008 this recommendation has been complied with and will not be repeated for fiscal year 2008 audit.

ATTACHMENT #3

AUDIT SENIOR

Job Summary

Responsible for the audit results, provide direct supervision and management to ensure execution of the audit process and results. Conducts independent audits according to the annual audit plan and develops appropriate documentation to support audit work performed.

Typical Duties

Conducts an effective risk assessment process and prepares an Annual Audit Plan that focuses on high risk areas.

Conducts independent audits according to the Annual Audit Plan and develops appropriate documentation to support audit work performed.

Measures and tracks results of audits performed through action plan follow-up procedures and tracking the impact of any identified revenue enhancement/cost savings.

Prepares and presents Annual Audit Plan, interim and annual reports of the results of audit activities to management and governance.

Demonstrates accuracy and thoroughness in all activities.

Assists in external audits as appropriate, collaborating with the external auditors to complete work assigned and provide feedback to the external auditors at the conclusion of the external audit engagement.

Minimum Qualifications

Education: Bachelor's degree in accounting or business related area required.

Experience: 10 years of Government Audit experience, 1-2 years of healthcare experience required.

Licensure or Certification: CGAP required, CIA or CISA preferred.

Knowledge, Skills, Abilities and Other Characteristics

Proficiency in financial analysis, reporting, auditing and risk assessment.

Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or governmental regulations.

Ability to effectively present information and respond to inquiries or complaints from employees, patients and/or their representatives, and the general public.

This position occasionally requires various types of physical exertion including, but not limited to climbing, lifting, pulling, pushing, prolonged standing or moving moderate weight.

ATTACHMENT #4

Memo

To: Luis Munoz, MD, Chair, Audit Committee, CCHHS

From: Carolyn C. Lopez, MD, Chair, Ad Hoc Work Group on Corporate Compliance

CC: file

Date: March 12, 2009

Re: Status Report on Ad Hoc Work Group on Corporate Compliance

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Since the appointment of the Ad Hoc Work Group on Corporate Compliance, efforts have been focused on identifying internal and external participants as well as meeting with CCHHS leadership to ensure smooth interaction of this effort with related internal activities.

Members of the Ad Hoc Work Group are:

Carolyn C. Lopez, MD, Institute of Medicine of Chicago
Mr. Jonathan Bode, Dept. of Orthopedics, University of Illinois
Ms. Tara Gurber, Vice President, Blue Cross
Ms. Gretchen Winter, Executive Director, U. of I. Center for Professional Responsibility in Business and Society

Ms. Linda Brodsky Director of Research Affairs
Deborah Fortier, JD
Dr. Aaron Hamb CMO Provident Hospital
Dr. Avery Hart CMO Cermak
Ms. Peggy Jones Oak Forest Corporate Compliance Officer
Ms. Dorothy Loving CFO of Provident Hospital
Ms. Gretchen Ryan Med Assets

The first meeting is being scheduled with the help of Mr. Small's assistant. This will be an organizing meeting and will lay out the work plan. We will begin with a gap analysis to determine, from a system perspective, those elements of a corporate compliance plan that are already in place and working (or not working). From that point, a determination will be made as to what, if any, policies need to be updated or developed. Since it appears that the recently passed stimulus package included revisions to HIPAA, an assessment will be made to determine what these changes are and how they might best be addressed.

Once these first steps are completed, the Work Group will consider issues around implementation and training of affected personnel. It is important that CCHHS has an effective infrastructure to have and maintain a strong corporate compliance program that is integrated in the culture of the organization.