

Minutes of the Meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Friday, January 19, 2024 at the hour of 9:00 A.M., at 1950 West Polk Street, Room 5301, in Chicago, Illinois.

**I. Attendance/Call to Order**

Chair Harrington called the meeting to order.

Present: Chair Joseph M. Harrington and Director Robert G. Reiter, Jr. (2)  
Director Otis L. Story, Sr.

Remotely  
Present: Director Hon. Dr. Dennis Deer, LCPC, CCFC (1)

Absent: None (0)

Director Reiter, seconded by Chair Harrington, moved to allow Director Deer to remotely participate in this meeting as a voting member. THE MOTION CARRIED UNANIMOUSLY.

Additional attendees and/or presenters were:

Nicole Almiro – Chief Corporate Compliance and  
Privacy Officer  
Jeff McCutchan – General Counsel

Alisha Patel – Assistant General Counsel  
Deborah Santana – Secretary to the Board  
Tom Schroeder – Director of Internal Audit

The next regular meeting of the Audit and Compliance Committee is scheduled for Friday, April 19, 2024 at 9:00 A.M.

**II. Public Testimony**

There was no public testimony submitted.

**III. Report from Chief Corporate Compliance and Privacy Officer (Attachment #1)**

**A. Action Items: Receive and File the following reports (Attachment #2)**

- CountyCare Compliance Program – FY2023 Annual Report
- Cook County Health System (Provider) Compliance Program – FY2023 Annual Report

Nicole Almiro, Chief Corporate Compliance and Privacy Officer, provided an overview of the Reports. The Committee reviewed the information.

### **III. Report from Chief Corporate Compliance and Privacy Officer (continued)**

The Report from Chief Corporate Compliance and Privacy Officer included information on the following subjects:

- Highlights of FY2023 - Metrics
  - Year-Over-Year Comparison
  - Contacts by Category
    - CCH Compliance Program
    - CountyCare Medicaid Health Plan Compliance Program, Recoveries
- Facing Forward – FY2024 Compliance Work Plan
- Receive and File Annual Reports
  - Cook County Health
  - CountyCare

Director Deer, seconded by Director Reiter, moved to receive and file the FY2023 Annual Reports of the CountyCare Compliance Program and the CCH System Compliance Program. THE MOTION CARRIED UNANIMOUSLY.

### **IV. Action Items**

#### **A. Accept Minutes of the Audit and Compliance Committee Meeting, October 20, 2023**

Director Reiter, seconded by Director Deer, moved to accept Item IV(A) the Minutes of the Audit and Compliance Committee Meeting of October 20, 2023. THE MOTION CARRIED UNANIMOUSLY.

#### **B. Any items listed under Sections III and IV**

### **V. Closed Meeting Items**

#### **A. Report from Director of Internal Audit**

#### **B. Discussion of Personnel Matters**

Director Deer, seconded by Director Reiter, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(1), regarding “the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity,” and 5 ILCS 120/2(c)(29), regarding “meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America.”



Cook County Health and Hospitals System  
Minutes of the Audit and Compliance Committee Meeting  
January 19, 2024

ATTACHMENT #1

# Corporate Compliance Report



**Audit & Compliance Committee of the CCH Board of Directors**

**January 19, 2024**



**COOK COUNTY  
HEALTH**

# Meeting Objectives

## Review

### Highlights of FY 2023

- Metrics
  - Year-Over-Year Comparison
  - Contacts by Category
    - Cook County Health Compliance Program
    - CountyCare Medicaid Health Plan Compliance Program
      - Recoveries
- Receive and File – Annual Reports
  - Cook County Health
  - CountyCare

### Facing Forward – FY 2024 Compliance Work Plan



# Metrics

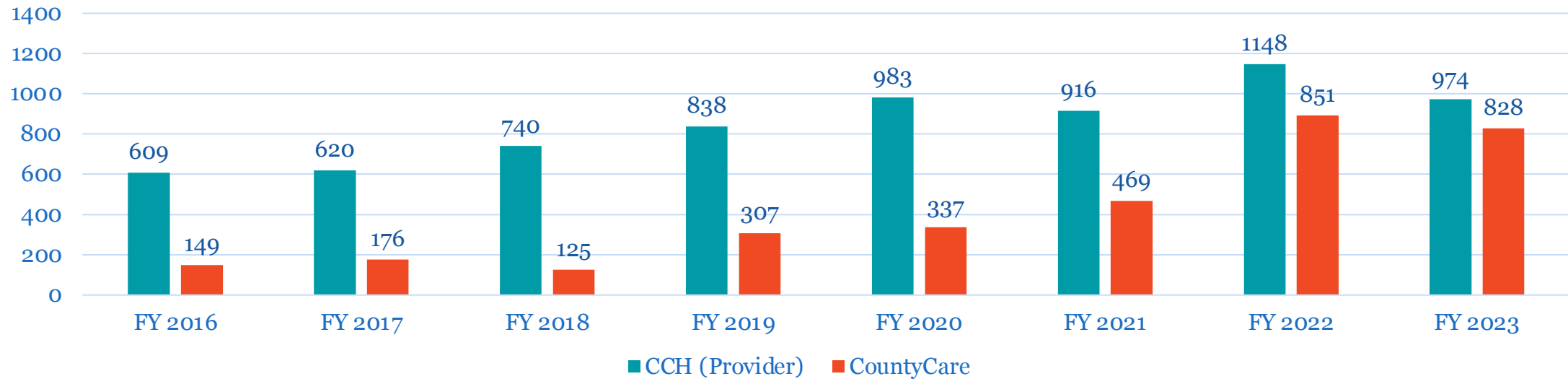
## Highlights of the Annual Reports



COOK COUNTY  
**HEALTH**

# Year-Over-Year Compliance Program Contacts

## CCH System Compliance and CountyCare Health Plan

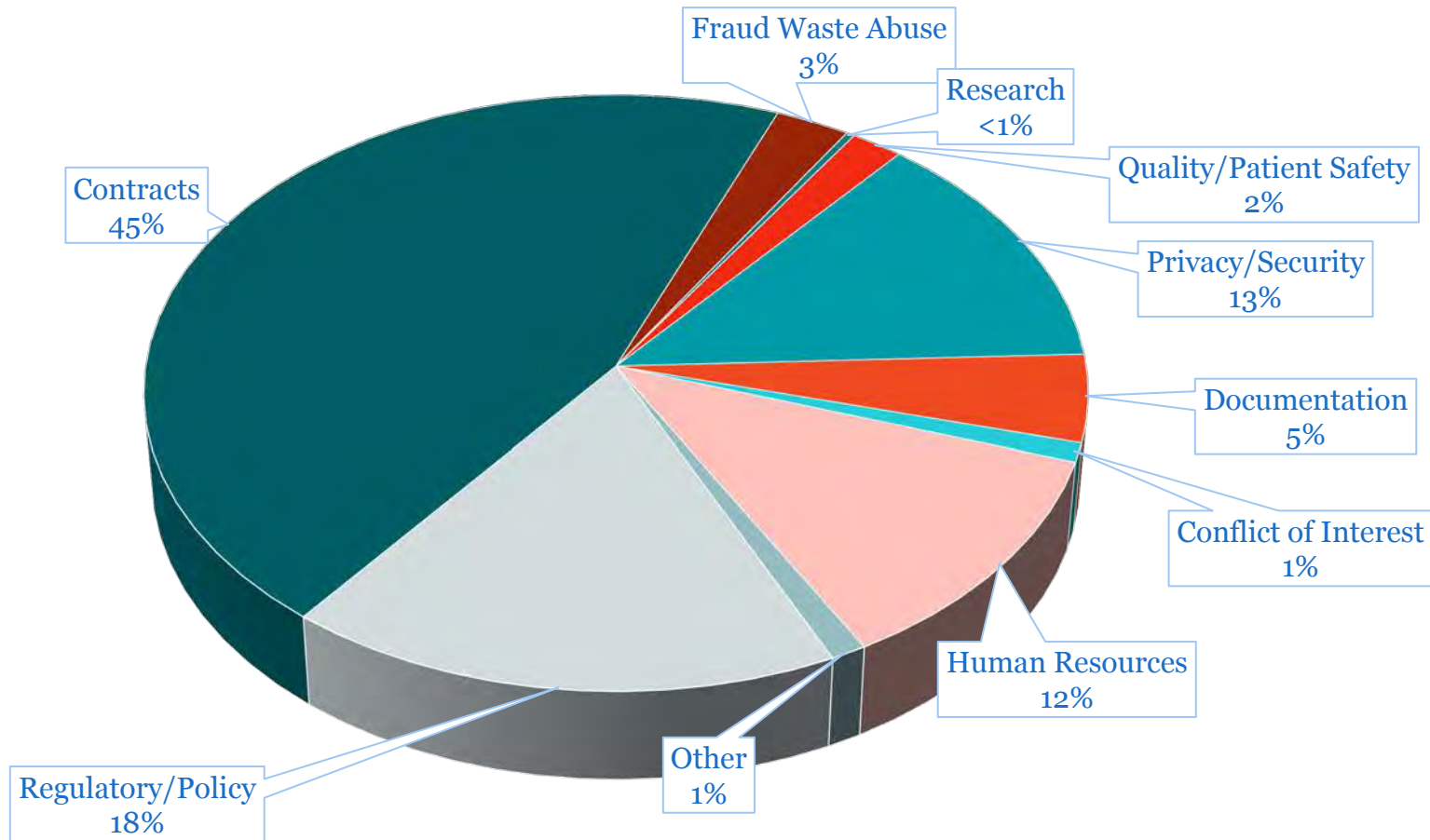




# FY 2023 Contacts by Category

## CCH System Compliance Program

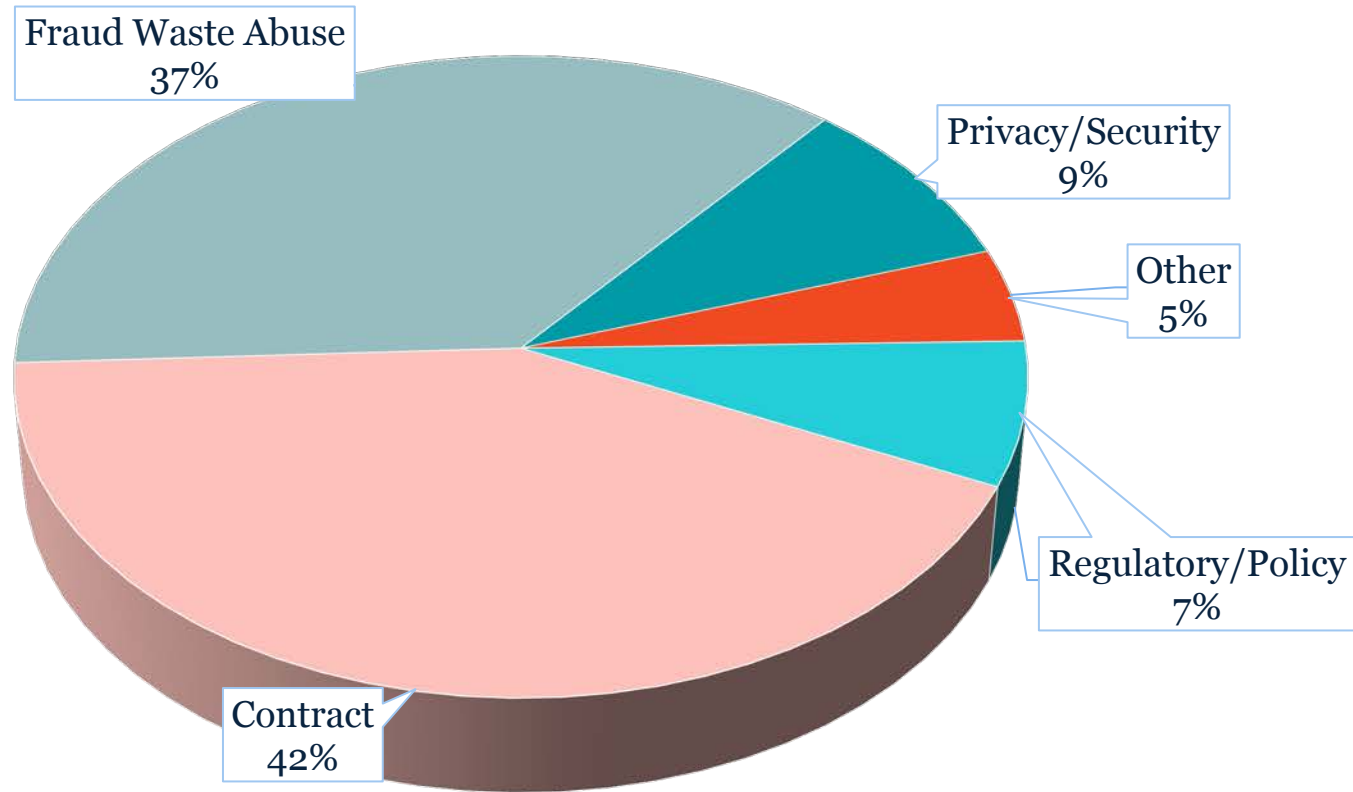
12/01/2022 – 11/30/2023



Categories	
Contracts	443
Regulatory/Policy	171
Privacy/Security (HIPAA)	129
Human Resources	115
Documentation	46
Fraud Waste & Abuse	27
Quality/Patient Safety	19
Conflict of Interest	10
Other	11
Research	3
	974

# FY 2023 Contacts by Category

## CountyCare Health Plan Compliance Program



12/01/2022 – 11/30/2023

Categories	
Contracts	351
Fraud Waste & Abuse	305
Privacy/Security (HIPAA)	73
Regulatory/Policy	60
Other (including below):	39
Quality/Member Safety	4
Conflict of Interest	4
Human Resources	3
Accurate Books & Records	2
<b>TOTAL</b>	<b>828</b>

# CountyCare Fraud, Waste and Abuse Recovery Metrics

## State Fiscal Year (S-FY) 2023 through S-FY 2024 Q1

S-FY	Reporting Period	Tips <sup>1</sup>	Referrals to HFS OIG	Overpayments Identified <sup>2</sup>	Overpayments Collected
2023	<u>Q1</u> 07/01 -09/30/22	71	30	\$1,445,090	\$632,343
2023	<u>Q2</u> 10/01 – 12/31/22	20	13	\$744,846	\$1,985,028
2023	<u>Q3</u> 01/01 – 03/31/23	64	13	\$926,018	\$3,162,686
2023	<u>Q4</u> 04/01 – 06/30/23	64	18	\$1,311,919	\$1,188,204

S-FY	Reporting Period	Tips	Referrals to HFS OIG	Overpayments Identified	Overpayments Collected
2024	<u>Q1</u> 07/01 – 09/30/23	68	48	\$1,226,051	\$836,559

## Proactive Preventative Loss

S-FY	Reporting Period	Overpayments Avoided
2023	<u>Q1</u> 07/01 -09/30/22	\$ 306,187
2023	<u>Q2</u> 10/01 – 12/31/22	\$ 287,672
2023	<u>Q3</u> 01/01 – 03/31/23	\$ 866,517
2023	<u>Q4</u> 04/01 – 06/30/23	\$ 216,169

S-FY	Reporting Period	Overpayments Avoided
2024	<u>Q1</u> 07/01 – 09/30/23	\$ 30,490

<sup>1</sup> The term **Tip** as defined by HFS OIG includes any allegations or incidents of suspected FWA opened on a CountyCare provider. A tip is a preliminary identification of a potential concern. Not all tips end up being referred to HFS OIG.

<sup>2</sup> The **Overpayments Identified** column indicates the currently outstanding amount that has been paid to a provider for identified inaccurate codes. These amounts may be supported through additional review of documentation submitted by the provider or may be offset if a provider elects to bill a corrected claim. The amount that is identified as an overpayment may also change if the provider is able to successfully appeal the audit/investigations findings (for example, if they are able to produced additional documentation to support their claim).



# Receive and File

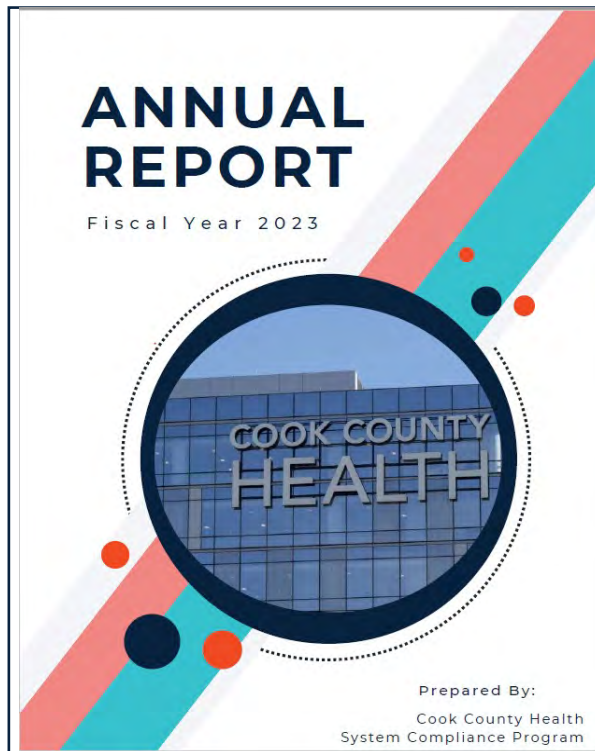
## Annual Reports



COOK COUNTY  
**HEALTH**

# Corporate Compliance Annual Reports

CCH System Compliance Program and CountyCare Medicaid Plan Compliance Program







# Facing Forward

**FY 2024 Work Plan**



COOK COUNTY  
**HEALTH**



# Facing Forward

## 2024 Corporate Compliance Work Plan

In addition to continued administration of the essential elements of the Corporate Compliance Program, (1) standards of conduct and policies; (2) oversight responsibilities; (3) education and training; (4) mechanisms for reporting; (5) enforcing standards; (6) monitoring and auditing; and (7) prevention, Corporate Compliance will embark on the following key initiatives in 2024:

- Redesign and update the CCH Code of Ethics & the Annual Compliance & Privacy Education Modules
- Development of supplemental training and education programs
- Expansion of auditing and monitoring activities for both Privacy and Compliance programs

# Questions?



COOK COUNTY  
**HEALTH**

Cook County Health and Hospitals System  
Minutes of the Audit and Compliance Committee Meeting  
January 19, 2024

ATTACHMENT #2

# ANNUAL REPORT

Fiscal Year 2023



Prepared By:

Cook County Health  
CountyCare Compliance Program

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## I. Introduction

CountyCare is a Managed Care Community Network (“MCCN”) health plan offered by Cook County Health (“CCH”) pursuant to a contract with the Illinois Department of Healthcare and Family Services (“HFS”) signed in 2014. Stated clearly via the mission statement adopted in 2021:

*“As a public, provider-led health plan, we improve our members’ lives by partnering with communities, supporting a vibrant safety-net, advancing health equity, and empowering providers to deliver integrated, member-centered care.”*

The operation of the CountyCare Medicaid health plan continues to be facilitated through CCH and its various subcontractors.

Twelve (12) years ago, CCH developed and implemented the CountyCare Compliance Program in order to adhere to the Medicaid Managed Care Program Integrity requirements outlined by both Centers for Medicare & Medicaid Services (“CMS”) and the contractual provisions in the MCCN Agreement with HFS, as well as the elements of an effective compliance program as recommended in the Department of Health and Human Services Office of Inspector General (“OIG”) Compliance Program Guidance publications.<sup>1</sup> The purpose of the CountyCare Compliance Program is to demonstrate the health plan’s ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, contractual requirements, CCH policies, procedures, and Code of Ethics.

This Cook County Fiscal Year (“CFY”) 2023 CountyCare Compliance Program Annual Report summarizes compliance activities addressed in CFY 2023 and identifies priorities for the future.

## II. CountyCare Compliance Program – Infrastructure and Scope

Below is an overview of the structure and organization reporting responsibilities of CountyCare Compliance, which includes the infrastructure supporting the comprehensive compliance program for CountyCare and its affiliates, as well as the scope of the program.

### **CountyCare Compliance Program Infrastructure**

During CFY 2023, the majority of CountyCare related compliance issues were handled internally by the Chief Compliance & Privacy Officer and the CountyCare Compliance Analyst, with the System Privacy Officer managing many of the Privacy related issues for CountyCare. CCH Compliance also continued its engagement with longtime department consultants, Strategic Management, LLC, to assist with interim compliance officer staffing services, including both critical and daily CountyCare and Privacy projects.

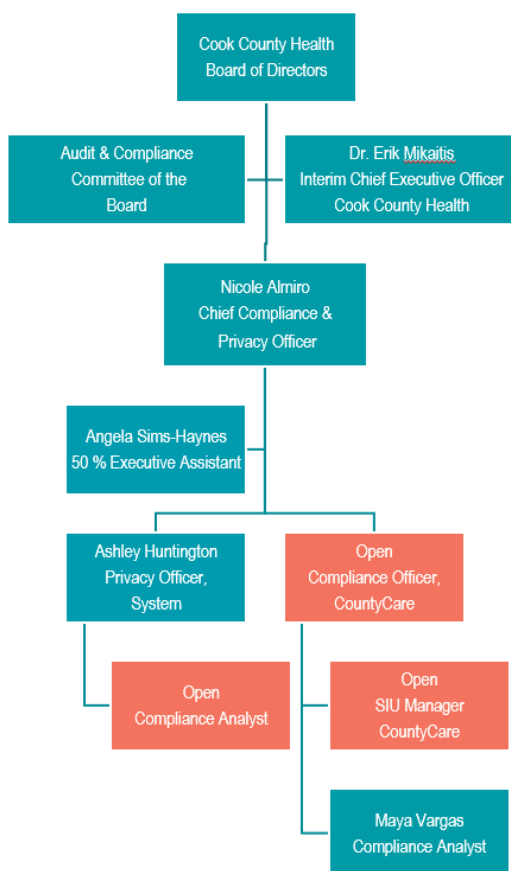
The current Compliance Departmental Organization Chart for CountyCare appears below.

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<sup>1</sup> See 42 C.F.R. §438.608 and Section 5.35 of the MCCN Agreement (2018-24-201), as amended by KA2 and KA5 in 2020. See also HHS OIG Compliance Guidance documents linked [here](#).



## Organization Chart



Adequate resourcing for the CountyCare Compliance Program remained a significant challenge in CFY 2023 and will continue to be a priority in CFY 2024. The role of Compliance Officer, CountyCare was still open at the close of CFY 2023, although a candidate has been identified for the position and is scheduled to begin in January 2024. Additionally, six positions remain open currently within the CCH Corporate Compliance office and efforts to fill the open positions are a critical priority for CFY 2024.

### CountyCare Compliance Program Scope

The CountyCare Compliance Program scope remains the same as in years past, with responsibilities focused on outlining guidelines and providing insight in order to:

- Comply with Medicaid Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan contract with HFS;
- Prevent, detect, and eliminate fraud, waste abuse, mismanagement, and misconduct (collectively “FWA”);
- Protect CountyCare members, providers, CCH, the State, and the taxpaying public from potentially fraudulent and/or unethical activities;
- Respond and provide guidance related to privacy, confidentiality, and potential or actual security breaches;

- Provide high-level oversight to CountyCare’s Grievances and Appeals Program; and,
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

CCH and CountyCare Compliance’s limited staffing has resulted in the necessity to focus only on core elements of the Compliance Program, including those activities mandated by the MCCN Agreement and required by HFS and HFS OIG.

When possible, the CountyCare Compliance Program also aims to continually evaluate and strengthen its working communication strategy to increase the CountyCare workforce awareness, including vendors and subcontractors, of the following topics:

- Code of Ethics;
- Privacy, Confidentiality, and Security;
- Accessibility of the Compliance Officer and the compliance team;
- Availability to report issues anonymously through multiple methods;
- Responsibility to report potential and actual issues;
- Consequences of not reporting; and,
- Non-retaliation protections.

The CountyCare Compliance Program's scope of work is subject to ongoing review and revision as deemed necessary to ensure ongoing compliance, especially in light of significant staffing challenges. It is designed to accommodate future changes in regulations and laws and may be updated to address issues not currently covered, issues related to new service offerings, or regulatory requirements.

### **III. Annual Compliance Program Activity – Performance of the Elements**

Below is a summary of the activities performed by CountyCare Compliance in CFY 2023 which also serves to demonstrate the effectiveness of the program, organized by the seven Compliance Program Elements for a comprehensive compliance program.<sup>2</sup>

As noted previously in this Annual Report, staffing shortages, among other challenges, have limited the CountyCare Compliance team’s scope during this fiscal year.

#### **Element 1:**

*An effective compliance program maintains and distributes a written Code of Ethics, as well as written policies and procedures, that promote the health plan’s commitment to compliance with all applicable requirements and standards related to program integrity and that address specific areas of potential FWA.*

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<sup>2</sup> As outlined in the Medicaid Managed Care Program Integrity requirements and by contractual provisions in the MCCN Agreement See 42 C.F.R. §438.608 and Section 5.35 of the MCCN Agreement (2018-24-201), as amended by KA2 and KA5 in 2020.



## Code of Ethics

The CCH Code of Ethics applies to all CountyCare personnel and includes but is not limited to, volunteers, independent contractors, consultants, business partners, providers, agents, and subcontractors. The Code of Ethics, as well as CCH's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations, sub-regulatory guidance, and contractual requirements.



## Compliance Plan

CountyCare also maintains a Compliance Plan demonstrating its commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and Code of Ethics/Standards of Conduct. The CountyCare Compliance Plan underwent an annual review in early 2023, with no significant revisions made. The CountyCare Compliance Plan continues to outline the specific compliance responsibilities of the Health Plan and program design, as well as specific CountyCare Compliance policies.

## Policies, Procedures and Contract Requirements

CountyCare Compliance engaged in the following activities impacting written guidance to promote and maintain an effective compliance program for CountyCare:

- Reviewed and revised multiple CountyCare health plan policies and procedures to ensure alignment with changes made to CountyCare's contractual and legal requirements, as well as best practices and changes in overall operations design.
- Developed, revised and distributed internal guidance to vendor partners related to revised processes for reporting FWA to HFS OIG.
- Ensured CountyCare personnel, providers, agents, and subcontractors had access to compliance documentation electronically and were provided with hard copies of compliance policies and procedures, upon request.
- Reviewed and revised template compliance contract language for new or updated requests for proposals (RFPs) and CountyCare contracts with delegated vendors and providers.

## Ad Hoc Activities/Guidance

CountyCare Compliance, in collaboration with CCH Compliance, worked with CountyCare leadership and operational areas to assess compliance with policies, procedures and/or regulatory

requirements and, in certain instances, provided guidance and/or assisted in the development of new policies, procedures and guidelines.

Examples of areas assessed:

- Requirements for new Health Benefits for Immigrant Adults (HBIA) / Health Benefits for Immigrant Seniors (HBIS) Population. CountyCare Compliance collaborated with operations to review and provide guidance for plan and benefit requirements related to the new HBIA and HBIA Medicaid populations that were implemented January 1, 2024.
- New Pharmacy Benefit Manager (PBM) Contracting and Implementation. CountyCare Compliance reviewed and provided guidance throughout contracting, pre-delegation audit and process implementation stages of bringing new a PBM on board with CountyCare, specifically related to requirements addressing corporate compliance, ethics, training, FWA investigations/audits, and the privacy of member protected health information.
- FWA Identified Related to COVID-19 Testing. CountyCare Compliance reviewed and provided guidance related to state and federal billing requirements for COVID-19 testing by lab providers in relation to several investigations conducted by partner Special Investigation Units (SIUs).
- Requirements Review for New Vendor Partners. As of SFY 2023, CountyCare Compliance is a nonvoting member for all requests for proposals (RFPs) that involve access to member health information. In this role, CountyCare Compliance reviewed and provided guidance regarding various compliance, FWA and HIPAA / information sharing requirements for new vendor partners. Additionally, CountyCare Compliance served as a voting member for RFPs related to non-emergency transportation (NEMT) and dental/vision vendors.
- Credit Balance Audits. CountyCare Compliance, in conjunction with the Evolent Payment Integrity team, reviewed and approved a new credit balance audit process for CountyCare network providers that will be implemented in CFY 2024.
- Expanded FWA Checks for New Provider Network Contracts. Provider Contracting and CountyCare Compliance continued to partner on FWA and sanction screening checks performed for potential CountyCare Network Providers. Process changes were made to incorporate additional review for provider types evidencing risk of FWA and to streamline efforts for efficiency. The ongoing effort related to performing FWA and sanctions screening checks continues to be significant due to the size and volume of the CountyCare provider network.
- Substance Use Disorder Confidentiality Requirements. CountyCare Compliance continued to monitor for guidance and commentary regarding updates to 42 CFR Part 2 related to the disclosure of substance use disorder records as it relates to CountyCare member information.
- Annual Vendor Audit Protocol Enhancement. CountyCare Compliance continued to partner closely with the Delegated Vendor Oversight team during their operational audits and incorporated a fulsome, standalone compliance audit, including testing of policy access, training completion and sanctions screening completion requirements across vendors.

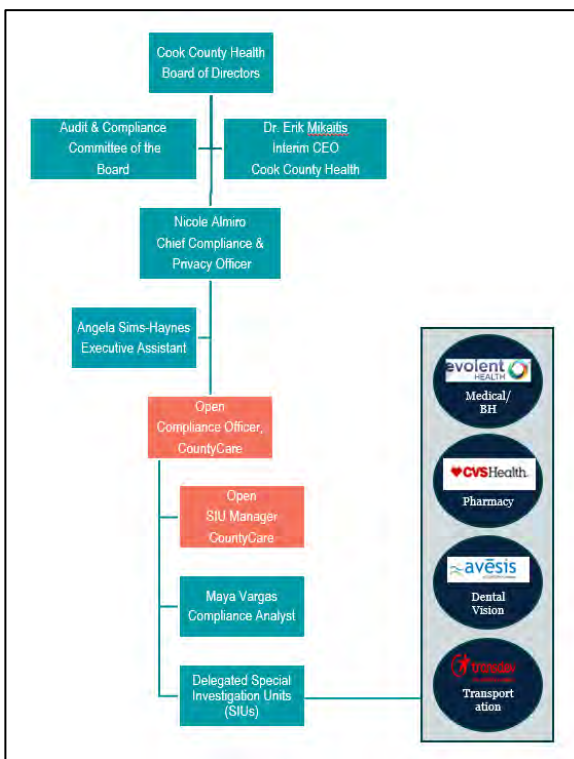
- Recipient Restriction (Lock In) Program (“RRP”). CountyCare Compliance continued to provide guidance and reviewed review revisions to policies and procedures addressing RRP processes, including how members are enrolled in the Proactive and Reactive Lock-In Programs, communications made to members/providers regarding lock-in changes, and the process for reporting RRP program operations to HFS OIG.
- System Access Tracker. Continued process for biannual monitoring of system access separate and distinct from CCH systems access as the CountyCare workforce accesses multiple external resources that contain sensitive information including member protected health information, by example through Third Party Administrators (“TPAs”).

## Element 2

*An effective compliance program is led by a Chief Compliance Officer, who reports directly to the organization’s Chief Executive Officer and the Board of Directors and who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. Oversight of the compliance program should be performed by Board and executive-level committees, consisting of members of the Board of Directors and senior management charged with the responsibility of operating and monitoring the compliance program.*

## Compliance Office and Oversight Committees

The graphic below illustrates the communication and reporting structure for the CountyCare Compliance program, which is embedded within CCH Compliance.



Nicole Almiro, the CCH Chief Compliance & Privacy Officer, reports to both the CCH Audit & Compliance Committee (ACC) of the Board and the CCH Chief Executive Officer (CEO). In turn, the CCH ACC and the CCH CEO each report to the full CCH Board of Directors. The Compliance Officer, CountyCare position reports directly to the CCH Chief Compliance & Privacy Officer.

The Compliance Officer, CountyCare role was vacant for CFY2023. During this time the Chief Compliance & Privacy Officer assumed primary operational responsibility for CountyCare Compliance in the capacity of interim Compliance Officer, CountyCare, with the assistance of the CountyCare Compliance Analyst, who managed the operations of the delegated Special Investigation Units (SIU).

The primary duties of the Compliance Officer, CountyCare did not change during CFY 2023.

The two committees tasked with oversight over the CountyCare Compliance Program met quarterly in CFY 2023, with their responsibilities outlined below:

- **Audit & Compliance Committee (ACC) of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management. The ACC of the Board receives periodic updates regarding the CountyCare Compliance program, including metrics related to program activities and FWA.
- **Regulatory Compliance Committee**, chaired by the Compliance Officer, CountyCare, provides oversight of and guidance to CountyCare operations to ensure regulatory compliance and fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Regulatory Compliance Committee also reviews CountyCare activity pursuant to Compliance Program requirements and contractual requirements, including, but not limited to audits, monitoring activity, and corrective action plans. The Regulatory Compliance Committee reports through the Chief Compliance and Privacy Officer to the ACC of the Board.

During CFY 2023, the CountyCare Compliance team also participated in the following regular meetings and quarterly committees to fulfill their responsibilities as a senior executive within Health Plan operations:



Additionally, in order to exercise proper oversight and management of the FWA activities carried out by the delegated Special Investigation Units (SIUs), the CountyCare Compliance team also attended the following meetings during the year:

- **Program Integrity / FWA Meetings**, comprised of delegated vendors occurring on a bi-weekly or monthly cadence, depending on the vendor and amount of activity. Led by the CountyCare Compliance team, the meetings provide an overview of the vendors' activities and serve as a forum to review, approve, modify, or reject the direction of audits, investigations, data mining efforts, and recoupment activity; and
- **HFS OIG MCO Subcommittee**, comprised of HFS OIG and Managed Care Organization's ("MCO") compliance members involved in the program integrity functions of their respective MCOs. This subcommittee meets monthly to review and share information regarding FWA activity as it relates to specific providers and trends.



### **Element 3**

*An effective compliance program should institute and maintain regular, effective education and training programs for all affected employees, including the Compliance Officer, Board of Directors, senior managers, and health plan employees, regarding the importance of complying with federal and state compliance related requirements.*

### **Education and Training**

CountyCare staff continues to complete mandated compliance related education and training both upon hire and on an annual basis, via modules on a learning management system (LMS). CountyCare Compliance also conducts annual compliance audits of delegated vendor partners, used to support health plan operations, to verify that vendor staff and subcontractors are completing compliance training upon hire and annually.

More targeted CountyCare Compliance training opportunities continued to be limited in CFY 2023 due to staffing constraints. However, CountyCare Compliance was able to participate in **monthly CountyCare orientation training sessions** to present content related to compliance, FWA and HIPAA. Orientation training is provided to new CountyCare employees once a month, which covers an introduction to all aspects of CountyCare for new hires (both permanent and contractual), with dedicated time for an introduction to the CountyCare Compliance Program and privacy guidance delivered in person by the CountyCare Compliance Analyst.

Additionally, updates regarding compliance related news items were provided to CountyCare senior leadership staff during quarterly Regulatory Compliance Committee meetings.

### **Element 4**

*An effective compliance program should maintain several lines of communication to receive complaints from employees, subcontractors, network providers, members and the HFS OIG, including the adoption of procedures to protect the anonymity of complainants (such as the use of a hotline) and to protect whistleblowers from retaliation. Issues reported via communication channels should be tracked, investigated, and reported (as needed).*

### **Receiving and Responding to CountyCare-Related Complaints**

Several lines of communication remained available for reporting issues and complaints related to CountyCare during CFY 2023 as follows:

<b>CountyCare Compliance Email</b>  countycarecompliance@cookcountyhhs.org	<b>CCH Corporate Compliance Hotline</b>  1-866-489-4949	<b>CountyCare FWA / Compliance Hotline (staffed by Evolent)</b>  1-844-509-4669	<b>CCH Online Reporting Portal</b>  www.cchhs.ethicspoint.com	<b>CCH Open Door Reporting Policies</b>
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All lines of communication are monitored in real time by CountyCare or Corporate Compliance staff, except the FWA/Compliance Hotline which is managed by Evolent (Third Party Administrator (TPA) for CountyCare). CountyCare Compliance meets with the Evolent team biweekly to discuss issues received through the hotline and appropriate responses to those issues, with urgent issues escalated via email. Where possible, reporters are allowed to remain anonymous via the hotline and reporting portal options.

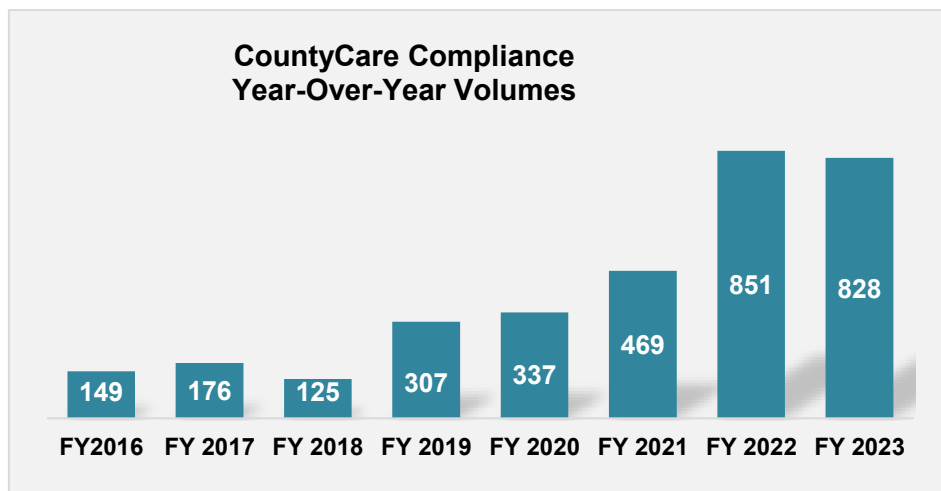
The CountyCare Compliance team followed established CountyCare Compliance processes for responding to issues and complaints received during the year. CountyCare Compliance tracks and identifies trends and patterns within its contacts and activities to further mitigate organizational risks and facilitate operational improvement. Additionally, trends and patterns within CountyCare Compliance reports and activities are presented to the Regulatory Compliance Committee, CountyCare Senior Leadership meetings, and the ACC of the Board, as appropriate.

Below are summary activity metrics from CFY 2023.

### **CFY 2023 CountyCare Compliance Contact Volume**

#### **1. Total Volume of General Compliance Contacts**

828 contacts were documented for the CountyCare Compliance Program during CFY 2023. The chart that follows illustrates the year-over-year activity, which shows that program activity remained fairly consistent, with only a 3% decrease in activity volume compared to the previous fiscal year. Decreased activity can largely attributed to ongoing staffing constraints.

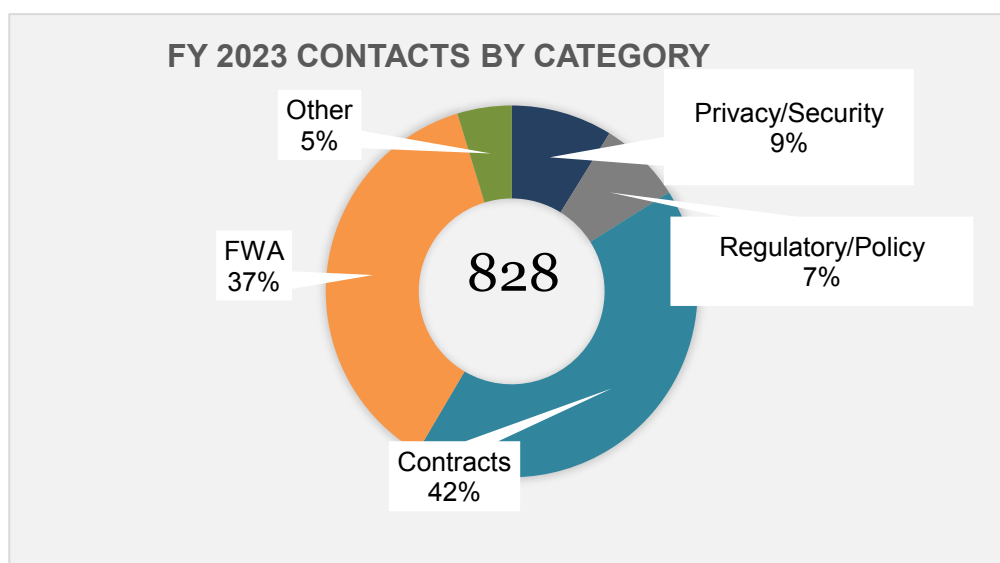


2. Inquiry/Issue Breakdown by Category CFY 2023 (December 1, 2022-November 30, 2023)

Categories have been defined to allow CountyCare Compliance to accurately organize and report compliance inquiries/issues received. The CFY 2023 CountyCare Compliance issues addressed fall within the following categories:

- Contractual Issues & Reviews
- Regulatory/Policy Matters
- HIPAA Privacy/Confidentiality
- Accurate Books & Records
- Fraud, Waste and Abuse
- Quality/Patient Safety
- Conflict of Interest
- Other

The chart below illustrates the volume of contacts received by CountyCare Compliance in CFY 2023, separated by issue category.



The associated category count follows:

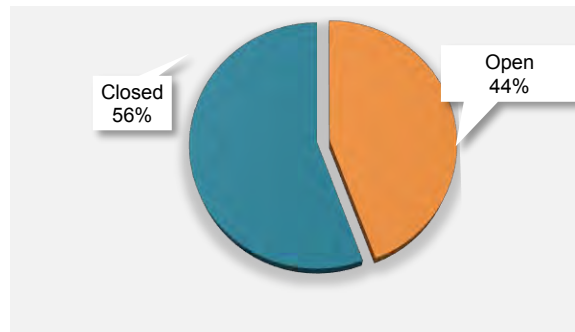
Categories	Count
Contracts/ Agreements	351
Fraud, Waste, Abuse	305
Privacy, Confidentiality and Security (HIPAA)	73
Regulatory/Policy	60
Other	39
<b>Total</b>	<b>828</b>

Issue types included in the “Other” category include queries regarding:

- Accurate documentation,
- Conflict of interest,
- Quality/member safety,
- Human resources, and
- Others, as applicable.

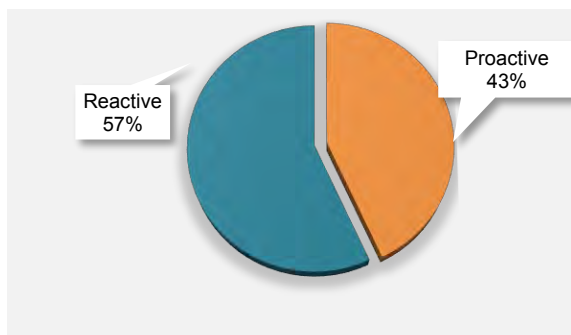
### 3. CFY 2023 Contact Status

Of the 828 contacts reported throughout CFY 2023, 461 contacts were resolved at the end of the fiscal year. The remaining 367 contacts are still in open status, although staffing constraints have resulted in a delay in updates to case closure metrics. As the majority of contacts brought to CountyCare Compliance involve partnerships with other operational areas or delegated vendors to address the concerns raised, carrying contacts over to the next FY is not viewed as problematic.



### 4. CFY 2023 Proactive vs. Reactive

Of the 828 CountyCare contacts received in CFY 2023, 43% (357) contacts were proactive while 57% (471) contacts were reactive. Proactive contact continues to be optimal for compliance because individuals seek guidance prior to the occurrence of an event or activity rather than retrospectively. This breakdown is very similar to what was reported in CFY 2022.



CountyCare Compliance continues to look forward to increasing awareness of CountyCare Compliance so issues may be addressed more proactively in the coming year when appropriate resources are available.

### 5. Privacy, Confidentiality and Security ("HIPAA")

As a covered entity and business associate of HFS, CountyCare is required to safeguard and protect the privacy of plan member information. During CFY 2023, this category accounted for roughly 9% (73 issues) of all CountyCare compliance activities.

During the year, 27 privacy-related incidents were reported to CountyCare Compliance. Incidents occur when, after a risk assessment, it is determined that the privacy event does not rise to the level of a HIPAA breach. The majority of the incidents involved mistakes in sharing member information incorrectly with either healthcare providers or other health plan operations staff via fax or email. In these cases, attestations were obtained that member information shared was destroyed and/or not used further. This was ten less incidents than

previously reported in CFY 2022. There were no reportable HIPAA breaches for CountyCare specific operations in CFY 2023.

Additionally, 33 contacts within the HIPAA category reflected guidance or review activities provided by CountyCare Compliance and/or the CCH Privacy Officer to discuss permissible access, use or disclosure of member protected health information by organizational staff and vendor partners or to provide member access to their health information.

Finally, 10 of the contacts included within the HIPAA category reflect activities related to reviewing and processing record requests for CountyCare member records as related to subpoenas and subrogation. While subpoena and subrogation requests are now operationally handled by CountyCare Finance (the process transitioned in November of 2022), Compliance still serves as a subject matter expert related to releases of specifically protected health information. This accounts for the decrease in this type of contact for CFY 2023, compared to the 22 contacts in CFY 2022 and 97 contacts reported for CFY 2021.

6. Fraud, Waste, and Abuse, Mismanagement and Misconduct (collectively, “FWA”)

A significant amount of time and effort is assigned to the prevention, detection and elimination of FWA by CountyCare Compliance. Of the 827 CountyCare contacts in CFY 2022, 37% or 305 contacts, were related to FWA. More information regarding CountyCare’s efforts related to these contacts can be found under Element 6 below, as the majority of these contacts were identified during or resulted in auditing, monitoring, or investigation-related activities.

### **Receiving and Responding to Communications from HFS OIG**

CountyCare Compliance is contractually obligated to receive and respond to communications received from HFS OIG, both regularly (e.g., monthly), as well as on an ad hoc basis. Types of communications received from HFS OIG include several types of Provider Alerts, which impact the various types of providers used to provide benefits and services to CountyCare members, including Providers, (Medical, Dental, and Vision), Pharmacies, Durable Medical Equipment (“DME”), Skilled Nursing Facilities (“SNFs”), Homemakers and Transportation providers.

Below is a summary of the volume of Provider Alerts, separated by notice type, received in CFY 2023 from HFS OIG, which CountyCare Compliance then communicated to its relevant SIUs and benefits administrators, as appropriate. Notably, the volume of Provider Alerts increased in CFY 2023 to 211, from 165 in the year prior, which evidences the increasingly active enforcement role held by HFS OIG over the last few years.

Provider Alert Type	CFY 2023	CFY 2022
Active Investigation (also known as “Deconfliction”)	8	7
Payment Withhold	16	13
Payment Suspension Release	8	9

Provider Alert Type	CFY 2023	CFY 2022
Disenrollment, Termination, and Voluntary Withdrawal	171	133
Reinstatement	8	3
<b>TOTAL</b>	<b>211</b>	<b>165</b>

### **Element 5**

*An effective compliance program maintains a system to respond to allegations of improper/illegal activities and coordinates with relevant departments to ensure enforcement of appropriate disciplinary action, using well-publicized disciplinary guidelines, against workforce members who have violated internal compliance policies, program-integrity-related requirements, applicable statutes, regulations or Federal health care program requirements.*

### **Enforcing Standards**

During CFY 2023, CountyCare Compliance and its delegated vendor partners exercised the scope of its enforcement standards through:

- Investigations and Guidance for Employee-Related Corrective Actions. CountyCare Compliance, in partnership with CCH Compliance, investigated employee related complaints (for example, those related to confidentiality complaints or conflict of interest) and provided guidance to involved employees and leadership to remediate the situations and avoid repetition of the incident.
- Monitoring Corrective Action Plans (“CAPs”), Deficiency Action Plans (“DAPs”), and Performance Improvement Plans (“PIPs”). CountyCare Compliance, in collaboration with the CountyCare Delegated Vendor Oversight program, monitors any CountyCare vendor placed on a CAP, DAP, or PIP for issues related to program integrity or compliance. During CFY 2023, no vendors were placed on a compliance or program related integrity-related CAP, DAP, or PIP.
- Privacy and Security (“HIPAA”) Breach Assessments. CountyCare Compliance, in collaboration with the Privacy Officer, maintains consistency in approach for breach assessments and provide provides guidance to CountyCare workforce members and business associates.
- Fraud, Waste, Abuse, Mismanagement and Misconduct (collectively, “FWA”) Monitoring. CountyCare Compliance collaborated closely with delegated Special Investigation Units (“SIUs”) to identify and mitigate potential FWA. This includes following processes for provider education, recovery of identified overpayments from providers, and network termination for non-compliance with network provider agreement provisions, where appropriate.



- Partnerships with Governmental and non-governmental Agencies. CountyCare Compliance continued its partnerships with the HFS, HFS OIG, the DOJ, and Illinois' Medicaid Fraud Control Unit ("MFCU"). CountyCare Compliance also collaborates with several organizations related to the detection of fraud and wrongdoing in the insurance industry, including other managed care organizations and health plans, the HealthCare Fraud Prevention Partnership ("HFPP"), National Insurance Crime Bureau ("NICB"), Midwest Anti-Fraud Insurance Association ("MAIA"), and the professional organization of compliance professionals, Health Care Compliance Association ("HCCA").

### **Element 6**

*An effective compliance program utilizes risk assessments, audits and/or other evaluation techniques to monitor program integrity and assist in the prevention and/or reduction of identified problem areas related to fraud, waste, abuse, mismanagement and misconduct.*

### **CountyCare Delegated Special Investigation Units**

Prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct (collectively, "FWA") remains a central component of the CountyCare Compliance Program.

To identify potential FWA, CountyCare Compliance partners with several delegated vendors, through their dedicated areas, commonly known as Special Investigation Units ("SIU"). The four SIUs operating on our behalf are pictured to the right. The CountyCare Compliance team provides direct oversight of program integrity activity. CountyCare Compliance is planning to pursue an "SIU Manager" role within the organization to provide additional support in CFY 2024.

Activities carried out by our SIUs are vital for ensuring that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, medically necessary care and preventing FWA in addition to protecting CountyCare members and providers.



### **Auditing and Monitoring Efforts for SFY 2023**

#### **Fraud, Waste, Abuse, Mismanagement and Misconduct (collectively, "FWA")**

CountyCare Compliance relies upon the monitoring, auditing, investigation, and utilization controls performed by the designated SIUs carried out by its delegated vendors. FWA activity matters are raised through multiple lines of communication, either to each delegated vendor or directly to CCH Compliance. All allegations are tracked and monitored to resolution. In addition, other auditing and investigation measures are undertaken through the SIUs.

CountyCare continues to utilize data mining, a proprietary catalogue of concepts developed by its SIUs, to analyze CountyCare claims and identify providers with unusual billing patterns and

reviews. CountyCare Compliance also investigates tips received from HFS, HFS OIG, other health plans, healthcare fraud groups, CountyCare staff, the media, and other sources to identify FWA.

Notably, during SFY 2023, there was a significant investigation focus on FWA related to COVID-19 testing claims submitted by lab providers. Potentially problematic COVID-19 testing claims were identified and flagged by CountyCare SIU partners, with comprehensive investigations initiated of the providers submitting the claims. Review and investigation by CountyCare SIU of providers included onsite visits, record reviews and interviews with lab staff (where appropriate).

All Program Integrity activity is tracked by State Fiscal Year (“SFY”) for state reporting purposes and not by County Fiscal Year (“CFY”). The SFY runs from July 1<sup>st</sup> through June 30<sup>th</sup> of each year. Metrics for both SFY 2023 along the first quarter of SFY 2024, as reported to HFS OIG every quarter, follow:

#### FWA Recovery Metrics (SFY 2023 – Q1 SFY 2024)

S-FY	Reporting Period	Tips <sup>3</sup>	Referrals to HFS OIG <sup>4</sup>	Overpayments Identified <sup>5</sup>	Overpayments Collected <sup>6</sup>
2023	<b>Q1</b> 7/01 -09/30/22	71	30	\$1,445,090	\$632,343
2023	<b>Q2</b> 10/01 – 12/31/22	20	13	\$744,846	\$1,985,028
2023	<b>Q3</b> 1/01 – 03/31/23	64	13	\$926,018	\$3,162,686
2023	<b>Q4</b> 4/01 – 06/30/23	64	18	\$1,311,919	\$1,188,204
2024	<b>Q1</b> 7/01 – 09/30/23	68	48	\$1,226,051	\$836,559

The results of the annual Program Integrity activities are reflected in the metrics above with a total of **\$6,968,261** collected in overpayments in SFY 2023. The amount recovered in SFY 2023 was slightly less than the \$7,239,722 collected in overpayments in SFY 2022. The overpayments recovered in the prior year were higher due to final processing of a backlog of recoveries that were temporarily suspended during the PHE.

<sup>3</sup> The term *tip*, as defined by HFS OIG, includes any allegations or incidents of suspected FWA opened on a CountyCare provider by the health plan. Often, tips reported to HFS OIG monthly are not fully vetted referrals, only preliminary information that SIUs are providing to HFS OIG in real time. Additionally, not all investigative activity is reported to HFS OIG via the Tips report (for example, data mining efforts or audits based on proprietary algorithms are not reported.)

<sup>4</sup> Where CountyCare Compliance identifies actual instances of FWA, mismanagement, or misconduct, information regarding the investigation is also *referred* to HFS OIG.

<sup>5</sup> *Overpayments Identified* indicates the dollar amount identified for possible overpayment (for example, the total amount paid to the provider for the identified inaccurate codes) during the quarter, based the investigation or audit conducted by the SIU. These amounts may be supported through additional review of documentation submitted by the provider or may be offset if a provider elects to bill a corrected claim.

<sup>6</sup> *Overpayments Collected* represents the dollar amount recovered from the provider/group, as allowable by the MCCN Agreement.

CountyCare Compliance continuously monitors the process to ensure appropriate action is taken, including reporting suspected FWA to HFS OIG. In SFY 2023, CountyCare referred 74 cases to the HFS OIG for possible FWA, which is consistent with the 73 cases referred during SFY 2022. 48 referrals have been made in SFY Q1 2023 alone, which evidences continuing efforts for increased oversight of CountyCare providers and is also the outcome of closing out open investigations with the transition of pharmacy benefit manager FWA operations during 2023.

Additionally, proactive preventative loss efforts carried out by CountyCare Compliance SIU vendor partners were able to prevent approximately \$1.67 million in losses in SFY 2023. Metrics related to proactive preventative loss for SFY 2023 and the first quarter of SFY 2024 are included below:

**Proactive Preventative Loss Metrics (SFY 2023 – Q1 SFY 2024)**

S-FY	Reporting Period	Overpayments Avoided
2023	<u>Q1</u> 07/01 -09/30/22	\$ 306,187
2023	<u>Q2</u> 10/01 – 12/31/22	\$ 287,672
2023	<u>Q3</u> 01/01 – 03/31/23	\$ 866,517
2023	<u>Q4</u> 04/01 – 06/30/23	\$ 216,169
2024	<u>Q1</u> 07/01 – 09/30/23	\$ 30,490

Annual Compliance Audit and Attestation

CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare’s delegated vendors in June 2023. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, compliance with the requirements of Section 9.2 of the MCCN. Additionally, each of CountyCare’s delegated vendors completed a compliance audit during CFY2023, which was facilitated through a partnership with the Delegated Vendor Oversight audit process.

Grievances and Appeals Activities

CountyCare Compliance continues to provide high-level oversight related to grievance and appeals activities at the plan level. As needed, guidance and assistance are provided related particularly to contractual and regulatory timeframes. Additionally, CountyCare Compliance participates in the quarterly CountyCare Grievance and Appeals Committee, as well as Delegated Vendor Oversight meetings.

**Regulator Audit Activity for CFY 2023**

CountyCare Compliance submitted comprehensive documentation in response to an audit request issued by HFS, via their external auditor Health Services Advisory Group (HSAG), during

FY 2023. In August of 2023, CountyCare Compliance submitted a large volume of documentation to HSAG with respect to review topics addressing Fraud, Waste and Abuse (Standard XIII) and Confidentiality (Standard IX). The onsite portion of the audit was conducted remotely by HSAG on September 25-27, 2023. HSAG has not yet submitted the final audit report to CountyCare, but no significant findings were communicated during the onsite report with respect to either of the audit standards reviewed.

## **Risk Assessment**

CountyCare Compliance is primarily focused on the prevention, detection, and elimination of FWA, in addition to monitoring and auditing other areas of compliance risk identified. Risk assessment is an ongoing, fluid and dynamic exercise within CountyCare Compliance, performed on a consistent basis by monitoring issues that arise via the various lines of communications offered by the Department as well as in day-to-day communications with CountyCare operations and benefit administrators. Where resources are available in CFY 2024, CountyCare Compliance will initiate an annual, unique to CountyCare risk assessment process with executive leadership and key thought leaders to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.

### **Element 7**

*Effective compliance programs maintain processes for the investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals. Additionally, processes are in place to ensure that prompt reporting of all overpayments identified or recovered to HFS OIG.*

## **Identification of Systemic Issues**

### **Sanction Screening Checks**

- CCH maintains a policy and procedure paralleling requirements set forth by the MCCN Agreement and the Department of Health and Human Services, Office of Inspector General, to ensure the screening of all contractors and workforce members. The goal of the policy is to avoid employing, engaging, contracting, or agreeing with any individual or entity excluded or “sanctioned” from participation in a federal health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services.
- Sanction screening requirements continue to be embedded within each CountyCare contract and each CountyCare benefit administrator is required to screen each provider in their networks.
- CountyCare Compliance continues to complete required sanction screening checks against four databases for all providers that are entering into contracts with CountyCare (i.e., in-network providers). These sanction screening checks occur prior to contracting with the provider/provider group/organization.

- Data is provided monthly to CountyCare Compliance to verify that sanction screening checks are conducted for all providers who receive payment from CountyCare (medical and behavioral health providers).
- As part of the annual compliance audit, CountyCare vendors are also required to produce policies, procedures and documentation to prove that sanction screening checks are performed in line with their contract requirements.

### **Prompt Reporting of Program Integrity Data to HFS OIG**

CountyCare Compliance is contractually obligated to submit data regularly to HFS OIG capturing its Program Integrity activities, particularly concerning potential FWA that is related to providers enrolled in the Illinois Medicaid program. In November of 2022, HFS OIG announced a new online FWA Reporting Portal that would be used as a mechanism for submitting information typically included in the monthly and quarterly reports. The FWA Reporting Portal is designed to receive case updates in “real time” and replaces the prior required monthly and quarterly FWA report submission processes.

CountyCare Compliance spends a significant amount of time and effort developing, reviewing, and submitting reports to HFS OIG via the portal, including comprehensive coordination and communication with the various SIUs to gather and validate the required Program Integrity related activity information and data. During CFY 2023, CountyCare Compliance developed and distributed revised internal policies and SIU partner guidance that outlined the new parameters for developing, reviewing and submitting information to HFS OIG via the portal, and leveraged existing Salesforce tools to help consolidate data from all the various SIU partners and streamline the reporting process.

### **Prompt Responses to HFS OIG Data Requests / Request for Information**

HFS OIG and its partner governmental agencies, such as the US Department of Justice (DOJ) and the Medicaid Fraud Control Unit (MFCU), regularly submit data requests to CountyCare for review and completion. These requests typically are focused on provider claims activity / encounter data but can also involve submission of FWA investigation and audit documentation, provider contracts, grievances/complaint data, or any number of items related to the health plan operations.

There are typically two types of requests:

#### **Requests for Information (RFI)**

These typically have a short turnaround time of between 48 hours and a few weeks and are centered on information related to specific providers or specific situations. CountyCare must diligently review the request and partner with the appropriate SIU benefit administrator to ensure timely and accurate responses are provided to HFS OIG.

**Requests for  
Audit  
(RFA)**

Audit requests are lengthier data requests from HFS OIG and their partner governmental organizations which require CountyCare to review the request, partner with the appropriate SIU benefit administrator and oversee, conduct and validate the audit scope and findings. These requests typically have a turnaround time of three to six months and may require varying levels of detail.

During CFY 2023, CountyCare received and responded to 42 requests for information submitted by HFS OIG, HFS, or other government agencies. This is a slight decrease from the number of requests received in CFY 2022, which was 49 requests.

#### **IV. Looking Ahead to CFY 2024**

In CFY 2024, CCH Compliance will continue to focus on maintaining adherence to contractual requirements and healthcare compliance best practices. As CountyCare relies heavily on delegated vendors, monitoring for adherence to CountyCare policies, and contractual, and regulatory standards is critical to ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing FWA, in addition to protecting CountyCare members and providers. The Program will continue ongoing activities related to risk reduction in the areas of compliance, policy implementation, and the development and implementation of monitoring and auditing efforts and will investigate all issues/complaints brought to the attention of CountyCare Compliance.

These priorities have been established for the CountyCare Compliance Program:

- Add staffing resources for the Program, including the onboarding of a new designated Compliance Officer for CountyCare and hiring of both a SIU Manager and a Compliance Analyst position, is central in the effort to better concentrate on initiatives designed to improve the Compliance Program, Program Integrity, and compliance presence for CountyCare operations.
- Strengthen CountyCare oversight of FWA Activities:
  - Continue efforts to streamline and formalize internal policies and written guidance across SIU partners to address parameters for developing, reviewing, and submitting FWA information to HFS OIG via the new FWA Reporting Portal.
  - Leverage existing Salesforce tools to create quality, efficient reporting necessary for performing appropriate governance and oversight of Program Integrity efforts, as well as tracking information reported via the FWA Reporting Portal.
  - Continue efforts to review and approve new concepts for data mining and clinical audit recovery activities.
  - Foster continued partnerships with HFS OIG and the State's MFCU to develop best practices in Corporate Compliance for CountyCare and enhance relationships with non-government organizations and other MCOs' to build a network of skilled investigators and increase effective Program Integrity efforts.

- Increase opportunities to deliver workforce education and knowledge sessions regarding the Compliance Department's duties, the compliance hotline, and a workforce member's duty to report to cultivate a culture of compliance throughout the Health Plan.
- Initiate a formal, unique to CountyCare, annual risk assessment process with executive leadership and key thought leaders to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.
- Develop and implement a formal CountyCare Compliance Auditing and Monitoring Plan, to outline how CountyCare Compliance audits and/or monitors identified compliance risk areas.
- Enhance existing collaboration with CountyCare Delegated Vendor Oversight program, to further hone the vendor-specific annual compliance audit protocols to allow for a more focused, comprehensive, and strategic audit process.
- Foster partnerships with other CountyCare departments and delegated vendors to fulfill contractual obligations in Program Integrity and state reporting and encourage proactive identification and discussion of issues with CountyCare Compliance.
- Uphold compliance with continuously changing contractual requirements and industry best practices as CountyCare continues as the largest Medicaid Managed Care Organization in Cook County.



# ANNUAL REPORT

Fiscal Year 2023



Prepared By:

Cook County Health  
System Compliance Program

# Executive Summary



The Fiscal Year (FY) 2023 Cook County Health (CCH) Compliance Program Annual Report provides a comprehensive look at the primary system-wide compliance activities and outcomes that the CCH Compliance Program accomplished in FY23 and outlines top compliance priorities for FY24. The scope, structure, core functions, and detailed activities of the CCH Compliance Program are also presented within.

Notable activities in FY23 include:

## **Policies & Procedures**

- Responsible for creation of two new policies and procedures, updated and edited several existing policies and procedures, and served as a reviewer and approver on a number of other system-wide policies and procedures.

## **Education**

- Provided broad and targeted education on a wide array of topics including:
  - Teaching physician requirements
  - Research financial conflicts of interest
  - Split/shared visits
  - Illinois Prescription Monitoring Program
  - Regulatory requirements for access to public telephones
  - Appropriately addressing Advance Practice Providers (APPs)
  - Prohibitions on password sharing
  - Handling suspicious faxes or requests for information

## **Auditing and Monitoring**

- Monitoring and auditing are interconnected elements of a robust compliance framework. Monitoring offers real-time vigilance, while auditing provides a thorough retrospective examination, and together, they contribute to the ongoing effectiveness of a compliance program. In FY23, the CCH Compliance Program engaged in monitoring in auditing activities in areas including:
  - Capturing the coinsurance notice, insurance card, and patient identification during registration
  - Teaching physician presence and attestation requirements
  - Evaluating how split or shared visits are conducted
  - Psychology department documentation for the individual behavioral treatment plan template
  - Doctor unassigned project

## **Dual Employment Survey**

- As with every year, the CCH Compliance Program administered the annual Dual Employment Survey. This year, however, Compliance spent considerable time revamping the survey to increase ease of use and ease of review for managers and senior leaders.
- To assist with issues and questions related to the survey, Compliance held “office hours” and invited any and all CCH workforce to visit during that time for added assistance and troubleshooting. As of the time this report was written, the completion rate for the survey was over 90%.

## **Committee Participation**

- CCH Compliance maintained a strong presence throughout the health system by serving on a number of committees including: Utilization Management; Serious Events Review Team (SERT) meeting; Data Governance; Data Loss Prevention (DLP); Ambulatory Physician Leadership; Research Executive Committee; Clinical Research Operations Committee; 340B Executive Oversight Committee; Value Analysis Committee; and the Controlled Substance Oversight Steering Committee.

At the conclusion of this report, the CCH Compliance Program outlines its projected goals for FY24, with major focus areas including: revision and improvement on key compliance documents such as the CCH Code of Ethics, Notice of Privacy Practices, and Business Associate Agreement; targeted updates across educational modalities, such as annual training and specialized training; and expansion of auditing initiatives for both privacy and compliance.

# About Us



## Scope and Jurisdiction of the Compliance Program

The focus of the Office of Corporate Compliance is to ensure understanding of and compliance with laws, rules, regulations, policies, and procedures across the Cook County Health (CCH) enterprise. Similarly, Corporate Compliance functions to prevent, detect, and correct potential and confirmed instances of non-compliance or wrongdoing.

The Office of Corporate Compliance incorporates two (2) distinct Compliance Programs: one encompassing CCH as a provider of healthcare services, and the other encompassing the CountyCare Medicaid Health Plan and Health Plan Services. Both programs have executive oversight by the Chief Compliance & Privacy Officer.

As this report focuses on the Compliance Program for CCH as a provider of healthcare services, the below describes the breadth of the jurisdiction for compliance on the provider side: CCH hospitals, including John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County; outpatient clinics comprising the Ambulatory Community Health Network (ACHN); correctional medicine at both the Cook County Jail and the Juvenile Temporary Detention Center; and the Cook County Department of Public Health (CCDPH). The Compliance Program also serves as a resource to providers, clinicians, all CCH workforce members, and all CCH “business associates” that have access to CCH protected health information (PHI) through contracted services. To an extent, the Compliance Program also indirectly serves as a resource to the CCH patient population by maintaining availability to assist patients with privacy and compliance concerns.

The Office of Corporate Compliance promotes a culture of compliance and enforces the message that all CCH workforce members have a duty to “do the right thing” and are responsible for prevention, detection, and reporting of potential instances of non-compliance. The Compliance Program extends organization-wide, regardless of one’s role at CCH.

# Compliance Program

## Activities



The CCH Compliance Program has been designed around the Seven Elements of an Effective Compliance Program, as detailed by the United States Federal Sentencing Guidelines from the Office of Inspector General. These elements include: implementing written policies and procedures; designating a compliance officer; conducting effective education and training; developing effective lines of communication; enforcing standards through well-publicized disciplinary guidelines; conducting internal auditing and monitoring; and responding promptly to detected offenses and undertaking corrective actions.

To ensure the above, the CCH Compliance Program focuses its efforts on prevention, detection, and correction, and serves as a subject matter expert in a number of areas that touch the health system. Significant elements within the purview of the CCH Compliance Program include:

- Monitoring of the regulatory landscape and interpretation of laws, rules, and regulations, as well as dissemination of pertinent information to CCH workforce.
- Development and maintenance of written policies and procedures designed to mirror regulatory requirements and outline expectations of CCH workforce. In the same regard, the CCH Compliance Program is responsible for adherence to the CCH Code of Ethics.
- Creation of a training program designed to educate all CCH workforce members on crucial laws rules, regulations, policies, and procedures relevant to their individual job functions. The CCH Compliance Program ensures the culture of compliance is communicated at New Employee Orientation and revisited during Annual Training. Beyond that, the CCH Compliance Program seeks out trends and patterns to determine where ad hoc training on specialized topics may be required.
- Publicizing the CCH Compliance Program and encouraging CCH workforce to leverage the Program as a resource. The CCH Compliance Program maintains a number of lines of communication, including a Compliance Hot-Line, three (3) compliance email inboxes, and has an in-person presence for drop in visits.
- Auditing and monitoring activities designed to ensure regulatory requirements are being met in key and high risk areas, such as those related to fraud, waste, abuse, and financial misconduct. Each year, the CCH Compliance program outlines its auditing and monitoring plan based on a risk assessment; however, additional activities may be added where allegations of non-compliance are presented and investigated.

- Partnership with Human Resources and departmental leadership across the CCH enterprise to ensure consistent enforcement of disciplinary standards where workforce members engage in policy violations or non-compliance.

# Element 1



## Policies & Procedures

*The development and distribution of written Code of Ethics, as well as written policies and procedures that promote the hospital's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, coding and billing risk areas, and financial relationships with physicians and other healthcare professionals.*

### Code of Ethics

The CCH Compliance Program serves as the guardian of the CCH Code of Ethics (Code), extending its influence and requirements organization-wide. The comprehensive Code applies to all CCH workforce members, fostering a culture of integrity and compliance. Employees, contractors, volunteers, consultants, business partners, providers, agents, and subcontractors all play pivotal roles in upholding the Code, aligning with CCH's mission, vision, and federal and state standards.

### Policies & Procedures

In FY23, the CCH Compliance Program dedicated a large portion of its time and resources to creating and maintaining, as well as refining and reinforcing compliance policies and procedures. These documents play a crucial role in promoting adherence to compliance standards. Beyond that, the CCH Compliance Program continued its work as a reviewer and approver on policies tangential to compliance, such as those in Finance, Registration, and Human Resources.

Policies created, reviewed, and/or updated include:

- **CC.001.01** Compliance Auditing and Monitoring Policy
- **CC.003.01** Compliance Program Hot Line Reporting Policy
- **CC.006.01** Corporate Compliance Reporting to the Governance Authorities of CCH
- **CC.007.02** Financial Conflict of Interest
- **CC.010.01** HIPAA De-Identification Policy
- **CC.011.01** HIPAA Permitted Uses and Disclosures
- **CC.022.01** Record Retention Policy
- **CC.025.01** HIPAA Limited Data Sets
- **CC.028.01** Non-Retaliation Policy
- **FIN.008.03** Outpatient Registration Policy
- **HR.001.03** Dual Employment
- **PE.006.01** Teaching Physician Presence Requirements



# Element 2

## Oversight by a Chief Compliance Officer



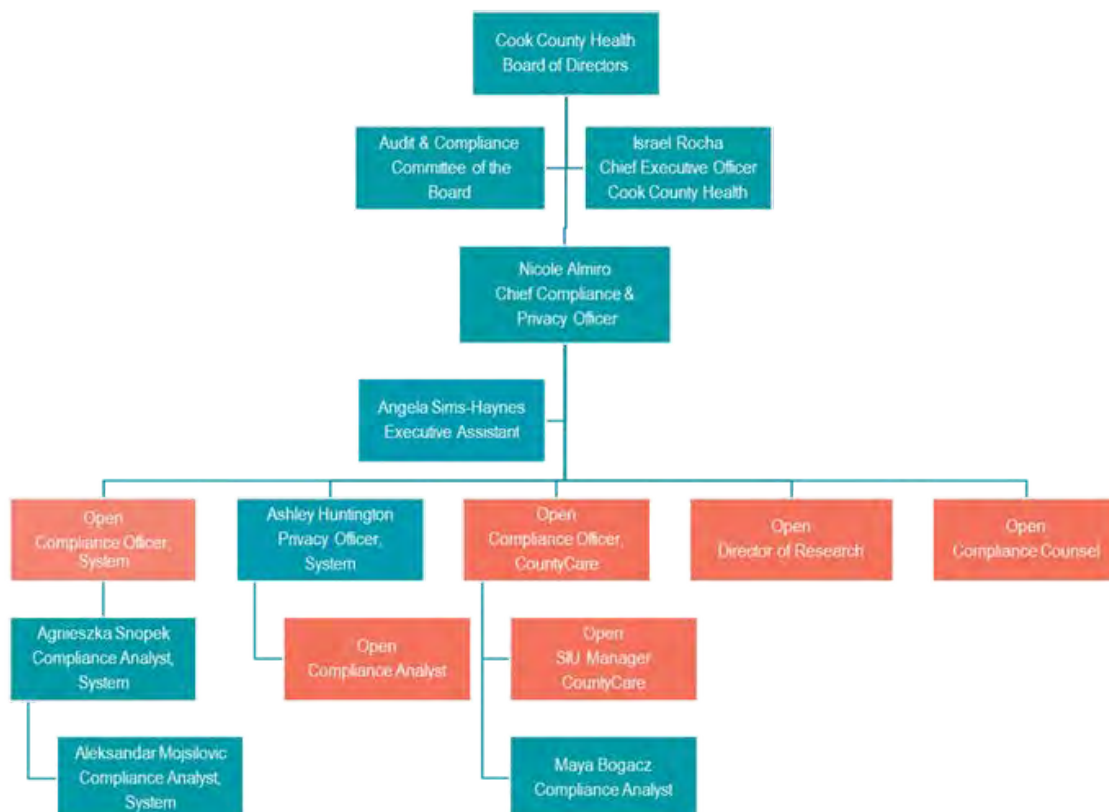
*An effective compliance program is led by a Chief Compliance Officer, who reports directly to the organization's Chief Executive Officer and the Board of Directors and who is responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. Oversight of the compliance program should be performed by Board and executive-level committees, consisting of members of the Board of Directors and senior management charged with the responsibility of operating and monitoring the compliance program.*

### Compliance Program Leadership, Reporting, and Committees

The Office of Corporate Compliance is overseen by Chief Compliance & Privacy Officer, Nicole Almiro. The Chief Compliance & Privacy Officer reports directly to the Chief Executive Officer (CEO) and the CCH Audit & Compliance Committee of the Board. In turn, the Audit & Compliance Committee and the CEO each report to the CCH Board of Directors.

The Chief Compliance & Privacy Officer oversees the implementation of compliance initiatives across CCH, the operation of the daily activities of the Compliance Program, and has primary responsibility for investigating allegations of misconduct and non-compliance at CCH.

The Office of Corporate Compliance is also staffed as described in the below departmental organizational chart:



# Element 3

## Education & Training



*An effective compliance program should institute and maintain regular, effective education and training programs for all affected employees, including the Compliance Officer, Board of Directors, senior managers, and health plan employees, regarding the importance of complying with federal and state compliance related requirements.*

In the CCH Compliance Program's ongoing commitment to fostering a culture of compliance, the education and training component of our Program is designed to equip all CCH workforce members with the knowledge and skills necessary to navigate the complex landscape of federal and state regulatory requirements. This section highlights the key education initiatives undertaken this fiscal year and the impact they have had on the organization.

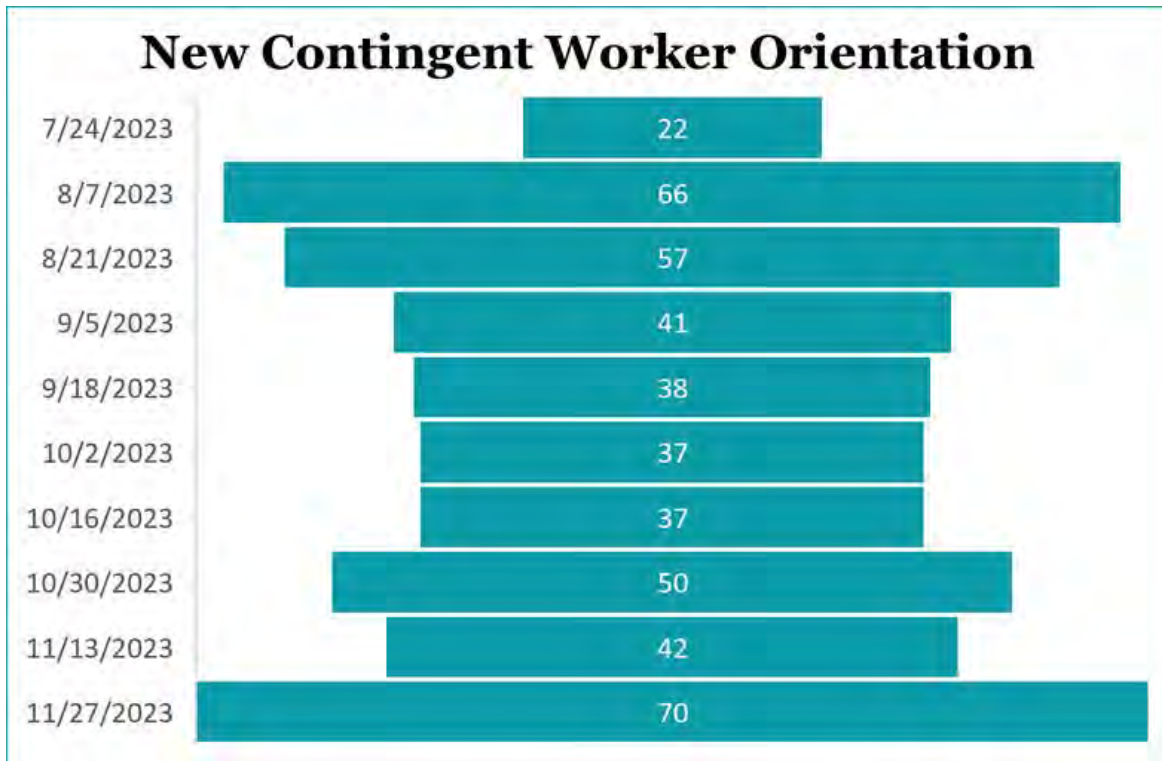
### New Employee Orientation

Beginning on July 17, 2023 through partnership with Human Resources, the CCH Compliance Program began tracking the compliance and privacy education provided to new employees during new employee orientation. Between July 17, 2023, and November 20, 2023, a total of 374 new employees participated in the compliance and privacy education. The above mentioned was completed over ten (10) sessions.



## Contingent Worker Orientation

Beginning on July 24, 2023, through partnership with Human Resources, the CCH Compliance Program began tracking the compliance and privacy education provided to new contingent workers. Between July 24, 2023, and November 30, 2023, a total of 460 new contingent workers participated in the compliance and privacy education. Education was conducted over ten (10) different sessions.



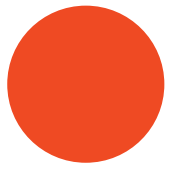
## Specialized and Targeted Education

- Teaching Physician Presence Requirements
  - With the roll-out of the Teaching Physician Presence Requirements Policy, the CCH Compliance Program revised and updated all teaching physician attestations statements for Evaluation and Management (E/M) services and procedures performed by residents under the supervision of teaching physicians. CCH Compliance Program provided education on both the policy and attestation statements to Executive Medical Staff, clinical department meetings, and ambulatory leadership forums.
- Financial Conflict of Interest
  - Developed a separate Research Financial Conflict of Interest (FCOI) policy to promote scientific integrity, patient safety and investigator/director objectivity. Teaming with the CCH Institutional Review Board (IRB) new IRB toolkit training sessions, CCH Compliance Program provided multiple in-person and virtual education sessions addressing CCH workforce members' FCOI reporting responsibilities.

- Split/Shared Visits
  - Conducted education pertaining to documentation and attestation requirements for split/shared visits in the Department of Obstetrics & Gynecology.
- Illinois Prescription Monitoring Program
  - Collaborated with the Department of Health Information Management to offer guidance and education on 720 ILCS 570/314.5 of the Illinois Controlled Substances Act pertaining to licensing requirements for providers prescribing controlled substances within Illinois.
- Regulatory requirements for access to public telephones
  - Based on Americans with Disabilities Act (ADA) and Illinois Public Health Code, provided guidance on ensuring patient access to public telephones in waiting room areas.
- Appropriately addressing Advance Practice Providers (APPs)
  - In collaboration with APP leadership, the CCH Compliance Program provided guidance and education on how Advance Practice Registered Nurses (APRNs) and Physician Assistants (PAs) should appropriately refer to themselves when with patients in accordance with state regulations.
- Password Sharing
  - The CCH Compliance program designed and presented a training on best practices for safeguarding login information and explained the how and why of implications of password sharing, including regulatory non-compliance, non-compliance with CCH policy, and potential for errors within the patient chart.
- Suspicious Faxes
  - Released system-wide guidance on handling suspicious faxes or other requests for patient information and served as a resource to departments experiencing a high volume of suspicious faxes.

# Element 4

## Open Lines of Communication



*An effective compliance program should maintain several lines of communication to receive complaints from employees, subcontractors, network providers, members and the HFS OIG, including the adoption of procedures to protect the anonymity of complainants (such as the use of a hotline) and to protect whistleblowers from retaliation. Issues reported via communication channels should be tracked, investigated, and reported (as needed).*

### Receiving and Responding to Complaints and Concerns

The Office of Corporate Compliance provides the CCH workforce with different reporting mechanisms to engender confidence in reporting sensitive information or instances of non-compliance. While the CCH Compliance Program always encourages CCH workforce members to report concerns directly to their supervisor or department leadership, the CCH Compliance Program does intake of concerns and inquiries that workforce members may not be comfortable discussing with leadership.

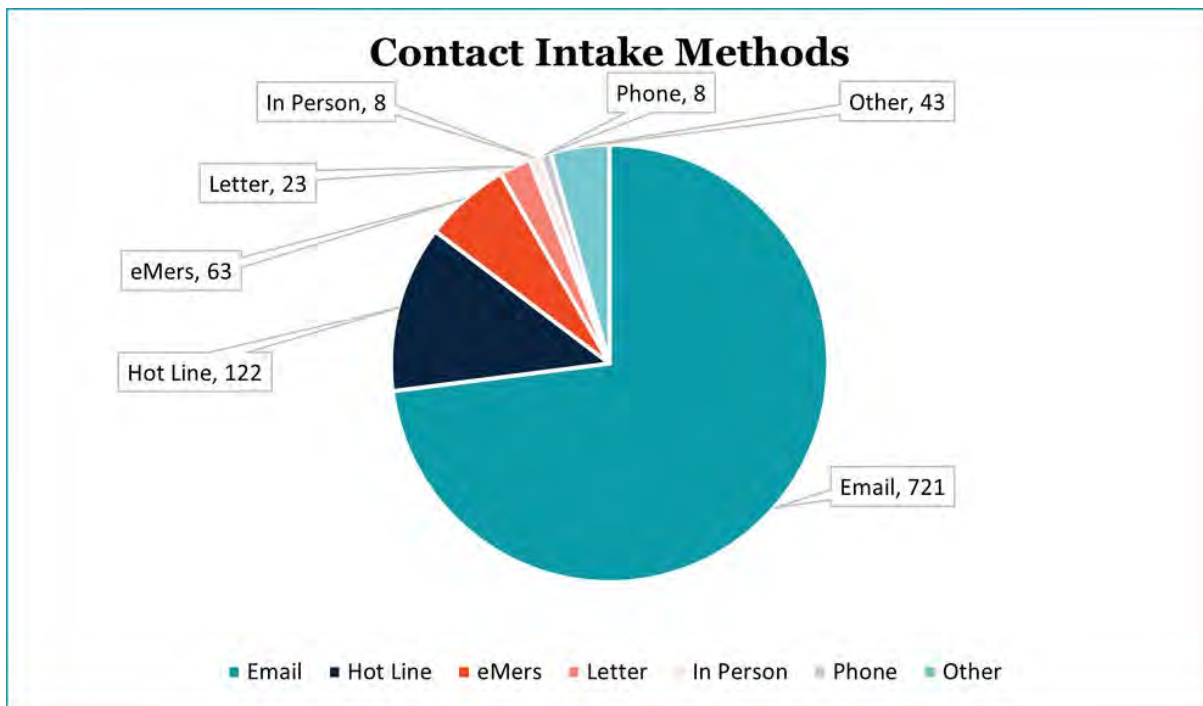
Modalities for communication include:

- **CCH Hot-Line:** administered by a third-party contractor, this hot-line which features a telephone number and online reporting portal.
- **Toll-free number:** provided for patients and members to inquire about privacy breaches.
- **Email Addresses:** three (3) separate email addresses for Compliance, Privacy, and CountyCare Compliance.
- **Direct Contact:** members of the CCH Compliance Program are all available by phone, email, or in-person.

### Intake Method Metrics

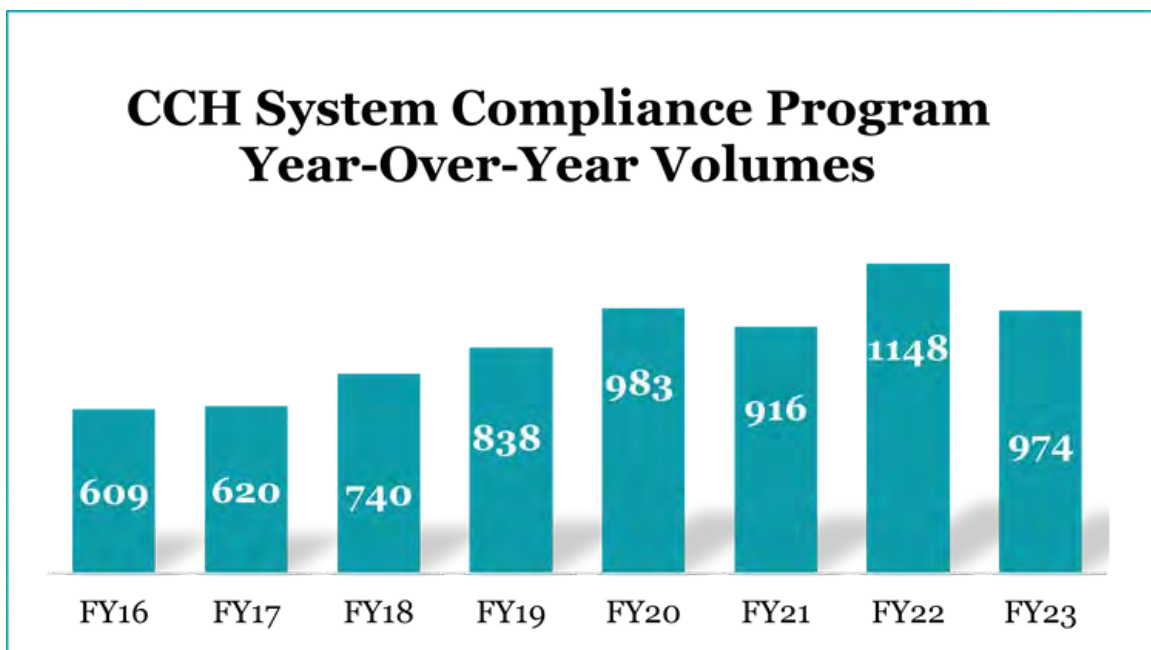
Below is a representation of how the CCH workforce and to some extent, the patient and member population, reached the CCH Compliance Program in FY23. Because many of the contacts received by the CCH Compliance Program are requests for guidance, the overwhelming majority of contacts come to the Program by email. Beyond that, the CCH Compliance Program sees a high utilization of its hot-line. Compliance staff also spend time combing the eMers system for issues that might be related to Compliance.

Of note, the below chart does not total 974, which is the total unique contacts for FY23. This can be explained because there are several initiatives that the CCH Compliance Program undertakes on its own without receiving an email, call, hot-line, or letter.



### Contact Volumes

The CCH Compliance program saw a total of 974 unique contacts in FY23. Below is a year-over-year comparison of the volume of unique contacts, which demonstrates the CCH Compliance Program's commitment to maintaining a high level of visibility and availability across the organization. Although the total volume of contacts did decrease slightly in FY23, the CCH Compliance Program focused its efforts on managing larger scale projects, especially those related to education and training and auditing and monitoring activities.



## **Contact Categories Managed by the CCH Compliance Program**

The CCH Compliance Program is responsible for serving as a subject matter expert in a number of areas that mirror those that appear in the CCH Code of Ethics. When tracking the contacts that come to the CCH Compliance Program, issues are bucketed into a category. As a note, the inclusion of a contact in a specific category does not substantiate the contact – rather, it classifies the contact as how it was brought to the CCH Compliance Program.

FY23 contact categories are as follows:

- Conflict of Interest
- Contracts/Agreements (including Business Associate Agreements (BAAs))
- Documentation
- Fraud, Waste, Abuse, and Financial Misconduct
- HIPAA Privacy, Confidentiality, and Security (note: although the category refers to HIPAA, this category also includes state and other privacy laws and regulations)
- Human Resources
- Quality/Patient Safety
- Regulatory/Policy
- Research
- Other (comprised of contacts that may include theft and miscellaneous compliance topics)

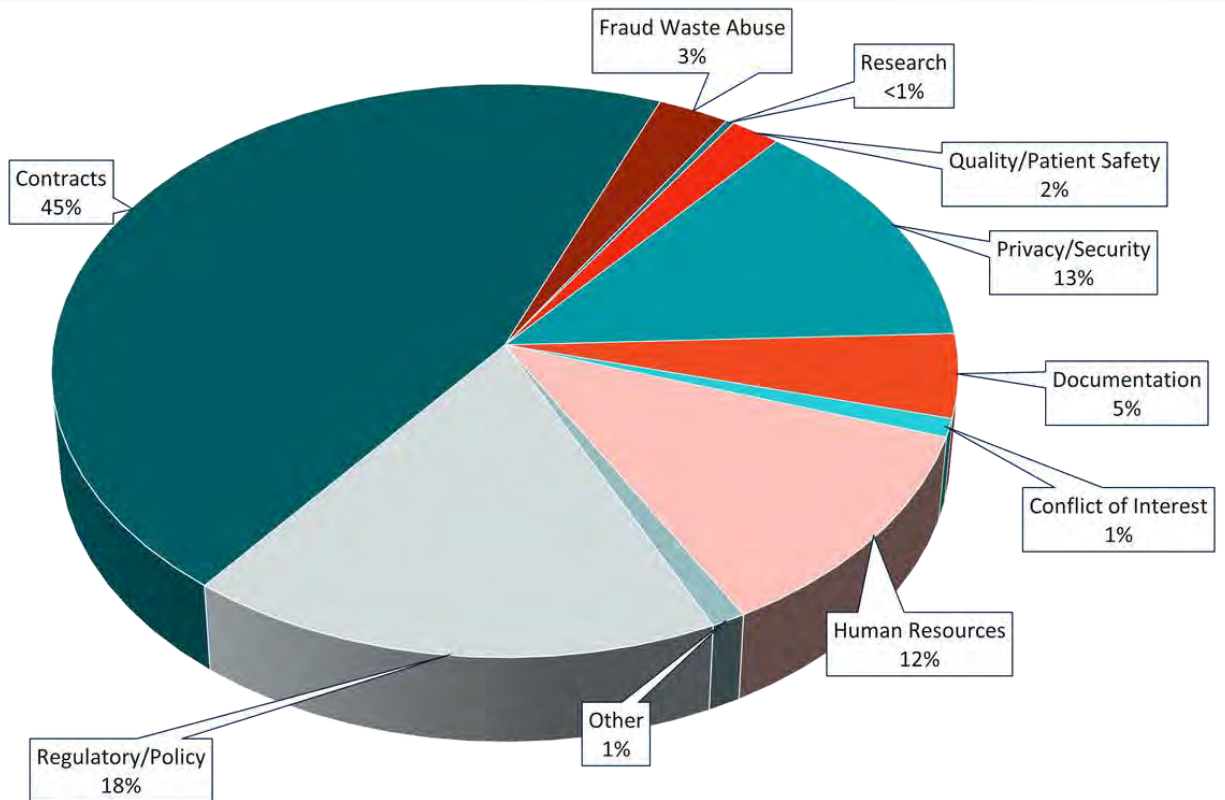
## **FY23 Unique Contacts by Category**

As with FY22, the CCH Compliance Program continued seeing a large volume of contracts and other agreements in FY23. These take up the largest share of contacts that come into the department. Outside of contracts, the CCH Compliance Program has expanded its work in the regulatory and policy space, which now takes up the second largest share of contacts. In third, the CCH Compliance Program continues its work in the HIPAA privacy, confidentiality, and security space and is pleased to report that much of its work is shifting toward proactive activities rather than responding to reactive incidents and breaches.

Of the HIPAA Privacy, Confidentiality, and Security contacts, there were approximately 17 confirmed privacy breaches. 16 of those breaches required notification to 19 patients. One breach, which was attributable to a third party vendor of CCH, resulted in notifications to approximately 1.2 million patients.



## FY23 Contacts by Category



Categories	Count	Categories	Count
Contracts	443	FWA	27
Regulatory/Policy	171	Quality/Patient Safety	19
HIPAA Privacy	129	Conflict of Interest	10
Human Resources	115	Other	11
Documentation	46	Research	3

# Element 5



## Enforcement Through Publicized Standards

*The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations, or Federal health care program requirements.*

The CCH Compliance Program is responsible for ensuring that the CCH workforce is equipped with the understanding of the organization's policies and procedures as well as knowledgeable on where to seek assistance for clarification on a given policy, law, rule, or regulation. The CCH Compliance Program does not seek punitive measures against the CCH workforce but rather explores opportunities for re-education where issues of non-compliance persist, or high-risk issues appear.

New in FY23, when requested by Human Resources, the CCH Compliance Program attends pre-disciplinary hearings to serve as a subject matter expert on policies and/or regulations that may have been violated by a workforce member.

The CCH Compliance Program serves as the guardian of the CCH Code of Ethics (Code), extending its influence and requirements organization-wide. The comprehensive Code applies to all CCH workforce members, fostering a culture of integrity and compliance. Employees, contractors, volunteers, consultants, business partners, providers, agents, and subcontractors all play pivotal roles in upholding the Code, aligning with CCH's mission, vision, and federal and state standards.

### Enforcing Standards in FY23

- Privacy Assessments Related to Access
  - The CCH Compliance Program responded to instances of inappropriate access to patient charts, produced audit trails as part of the investigation, and worked with departmental leadership to implement corrective action, including re-education and disciplinary action where appropriate.
- Privacy and Security Breaches
  - The CCH Compliance Program investigates all privacy and security incidents and makes the final determination as to whether a breach occurred. Where a breach occurs, the CCH Compliance Program ensures timely notification to the patient and all government regulators. Once notification is completed, the CCH Compliance Program worked with departmental leadership to provide re-education for workforce members involved in the breach.

- Conflict of Interest
  - When a potential conflict of interest presents, the CCH Compliance Program provides guidance and develops conflict management plans.
- Partnership with Governmental Agencies and Regulators
  - As inquiries and investigations come in from governmental agencies and regulators, the CCH Compliance Program ensures timely response and cooperation with these partners.
- Ensuring CCH Resources are Used Only for CCH Purposes
  - The CCH Compliance Program investigates potential instances of misuse of CCH resources and ensures that workforce members are equipped with knowledge on how to appropriately use CCH's resources for work purposes only.

# Element 6



## Monitoring & Auditing

*Monitoring and auditing are two integral components of an effective compliance program, working in tandem to ensure adherence to regulations, policies, and ethical standards. While they share some similarities, they serve distinct purposes in the overall compliance management process.*

*Monitoring is an ongoing, systematic process of tracking and overseeing activities, processes, and transactions within an organization to identify potential compliance issues in real-time.*

*Auditing is a periodic and systematic examination of an organization's processes, controls, and records to assess compliance, identify areas of improvement, and provide an independent and objective evaluation.*

Monitoring and auditing form the bedrock of our proactive compliance program, ensuring adherence to laws, rules, regulations, policies, procedures, and ethical standards. Below is a snapshot of large-scale monitoring and auditing activities undertaken in FY23:

### **FY23 Monitoring and Auditing Initiatives**

- Capturing Co-Insurance Notice, Insurance Card, and Patient Identification
  - This audit was conducted in January 2023 and included an assessment of the CCH policies and Centers for Medicaid and Medicare Services (CMS) regulations for capturing co-insurance notice, insurance card, and patient identification. In March 2023, following the audit findings, ACHN leadership re-educated employees on the Medicare Off Campus Co-Insurance form process and Outpatient Registration Policy. This re-education also covered the proper procedures for capturing the co-insurance notice, patient identification and insurance card information during patient encounters.
  - A second audit was conducted in November 2023 after education on this topic was administered to assess whether ACHN registration workforce members improved compliance with these requirements.
- Teaching Physician Presence/Attestation
  - CMS has specific guidelines regarding the supervision and documentation requirements for teaching physicians involved in the care of Medicare beneficiaries. These guidelines aim to ensure that services provided in teaching settings are appropriately documented and meet Medicare billing requirements.
  - This audit involved a thorough examination of medical record documentation to verify that teaching physicians appropriately attested to their presence, involvement, and decision-making in patient care.

- Billing records were also reviewed to determine that CCH is following correct billing requirements for services involving teaching physicians and confirm that the billing reflects the actual level of supervision provided.
- Split/Shared Visits
  - The CCH Compliance Program conducted an audit on split/shared visits to determine whether medical record documentation and billing comported with applicable laws and regulations. The audit focused on the Obstetrics and Gynecology department and targeted education was created in response to audit findings.
- Psychology and Psychiatry Department
  - As part of its monitoring efforts, Corporate Compliance undertook monitoring of the Psychology and Psychiatry department's documentation. In collaboration with Department of Health Information Management, documentation related to claims in Psychology and Psychiatry department associated to Behavioral Health was reviewed. To improve processes in this area, the Individual Behavioral Treatment Plan template was revised and implemented by department.
- Doctor Unassigned Project
  - In response to a reported potential safety issue of unassigned providers being added to lab and radiology orders, the CCH Compliance Program performed a root cause analysis and partnered with a multidisciplinary team including Finance, Health Information Systems, Medical Staff, and others
  - Implemented system error cleanup, new workflows, and continued monitoring to ensure departmental awareness and correction moving forward.

# Element 7



## Response & Corrective Action

*Response and Corrective Action are essential components of managing and addressing non-compliance with regulatory requirements, standards, and policies. A robust response and corrective action process help organization identify, rectify, and prevent issues that may compromise patient safety, quality of care, and overall regulatory compliance.*

### FY23 Response and Corrective Action Initiatives

- Capturing Co-Insurance Notice, Insurance Card, and Patient Identification
  - Partnered with ACHN leadership to establish and implement feasible corrective actions to ensure coinsurance notices, insurance cards, and patient identifications are captured during each patient encounter.
- Dual Employment
  - The CCH Compliance Program, in collaboration with external consultants, administered an updated and improved version of the 2023 Dual Employment survey. The survey is a critical tool for promoting transparency in alignment with CCH's mission as a safety net healthcare provider. CCH employees, as part of their annual responsibilities, are required to complete this survey to safeguard the interests and assets of CCH, the community, County of Cook, taxpayers, and the public. Employees are personally accountable for avoiding conflicts of interest, disclosing potential conflicts, and refraining from accepting gifts linked to CCH business transactions. The dual employment survey must be completed annually, upon entry into County service at CCH, initiation of external dual employment, schedule changes, and cessation of external activities. The Dual Employment survey encompasses various aspects such as outside employment, purchasing decisions, gifts, academic activities, outside influence, financial interest, research, and others.
- Improper Access to PHI
  - Where allegations of improper access to PHI occur, the CCH Compliance Program promptly investigates with the help of auditing tool, P2Sentinel. This report shows the Program on a second by second basis who accessed PHI, what they accessed, and how long they spent accessing it. The CCH Compliance Program then works with departmental leadership to determine whether the access was appropriate and if disciplinary action is warranted, works with the manager and Human Resources to implement.



- Split/Shared Visits
  - Corporate Compliance audit revealed room for improvement for documentation and billing of split/shared visits in the Obstetrics and Gynecology department. Upon identifying this item, Corporate Compliance met with and educated necessary providers. Additionally, this audit indicated that systemwide education on this topic is beneficial to the organization and was placed on the annual audit plan for fiscal year 2024.
- Sanction Screening
  - As of January 2023, CCH contracts with a new vendor to assist with the mandatory sanction screening of workforce members. Through change in processes, opportunity for correction in capturing workforce member personal information was identified. Corporate Compliance and Human Resources are working on enhancing and expediting requests for additional employee and contractor information to ensure workforce members are not listed on any of the lists of sanctioned individuals.
- Teaching Physician Attestations
  - Upon internal monitoring and auditing, it was confirmed that CCH will benefit from creation of several CMS approved templates for teaching physicians. In collaboration with the Department of Health Information Management, Health Information Systems and Clinical leadership, several templates for teaching physicians were created and implemented. Additionally, the new teaching physician policy was created and placed on the 2024 annual compliance plan for system wide education for providers.

# Looking Ahead

## Planning for Fiscal Year 2024



Planning for compliance activities is an organic and ongoing process that takes into consideration a risk assessment, enforcement trends from CCH's regulators, and high risk and high priority items within the system. Looking ahead to FY24, the CCH Compliance Program will continue serving as a trusted and reliable resource for all workforce members within CCH, as well as CCH patients, CountyCare members, vendors, and the public. CCH Compliance expects the following will be major focus areas:

- Code of Ethics
  - Revise our CCH Code of Ethics to provide practical and structured guidance on CCH expectations regarding integrity and compliance to our board, workforce members, contractors, students, volunteers, and business partners
- Learning System Management
  - Edit and update CCH Compliance Program's three (3) annual compliance education modules (Code of Ethics, Fraud, Waste, and Abuse, and Privacy) to upgrade and enhance the interactive learning experience.
- Shared/Split Services
  - Provide education and training on the collaboration and documentation requirements when and E/M service is shared between a physician and Non-Physician Provider (NPP) from the same group practice.
- Expansion of Privacy Initiatives
  - Engage in proactive privacy monitoring, including audits of the physician CCH space and audits of user access logs. Develop and administer broad privacy education on a quarterly basis as well as specialized privacy education based on audit results. Implement business associate monitoring to ensure PHI is safeguarded by CCH vendors.
- Revision of Key Privacy Documents
  - As the privacy space continues to evolve and become more dependent on technology, the CCH Compliance Program intends to revisit the organization's Notice of Privacy Practices and Business Associate Agreement and make appropriate updates.
- Teaching Physician Attestation Audit
  - Determine the effectiveness of Teaching Physician Presence and attestation education sessions by auditing a percentage of completed encounters in both the inpatient and outpatient setting to determine if the selected attestation meets regulatory requirements.

- Advance Beneficiary Notice of Non-Coverage (ABN).
  - The Centers for Medicaid & Medicare Services (CMS) requires that an ABN be issued to patients when an item or service is expected to be denied due to lack of medical necessity. CCH Compliance Program will audit a sampling of services for which medical necessity may be lacking due to frequency issues or lack of a documented diagnosis.
- Prior-Authorization Requirement
  - Certain services/medications require prior authorization to obtain reimbursement from third-party payers, including Medicare and Medicaid. Select services requiring prior authorization will be audited by CCH Compliance Program for compliance with these requirements.