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, February 19, 2021 at the hour of 11:00 A.M. This meeting was held by remote means only, in compliance with the Illinois Open Meetings Act.

I. **Attendance/Call to Order**

Chair Koetting called the meeting to order.

**Present:** Chair Mike Koetting and Directors Hon. Dr. Dennis Deer, LCPC, CCFC; Ada Mary Gugenheim; and Robert G. Reiter, Jr. (4)

Board Chair M. Hill Hammock (ex-officio) and Directors Robert Currie, Mary Driscoll, RN, MPH; Joseph M. Gerald Bauman (Non-Director Member)

**Absent:** None (0)

Additional attendees and/or presenters were:

- Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
- Jeff McCutchan – General Counsel
- Israel Rocha, Jr. – Chief Executive Officer
- 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, May 21, 2021 at 11:00 A.M.

II. **Electronically Submitted Public Speaker Testimony**

There were no public testimonies submitted.

**Note** – action was taken on Agenda Items III(A), IV(A) and V(A) in one (1) combined motion.

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

A. Action Items – Receive and File the following reports:
   - CountyCare Compliance Program – FY2020 Annual Report
   - Cook County Health System (Provider) Compliance Program – FY2020 Annual Report

Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, provided an overview of the information contained in the Report and two (2) Compliance Program Annual Reports. The Committee reviewed and discussed the information.

IV. **Report from Director of Internal Audit** (Attachment #2)

A. Action Item – Approval of proposed Internal Audit Charter

Tom Schroeder, Director of Internal Audit, provided an overview of the information on the proposed Internal Audit Charter.

V. **Action Items**
A. Accept Minutes of the Audit and Compliance Committee Special Meeting, October 14, 2020

Chair Koetting inquired whether any corrections were needed to be made to the Minutes.

B. Any items listed under Sections III, IV, V and VI

   Director Gugenheim, seconded by Director Deer, moved to receive and file the County Care and CCH (Provider) Compliance Program FY2020 Annual Reports; approve the proposed Internal Audit Charter; and accept the October 14, 2020 Special Meeting Minutes. On the motion, a roll call vote was taken, the votes of yeas and nays being as follows:

   Yeas:  Chair Koetting and Directors Deer, Gugenheim and Reiter (4)
   Nays:  None (0)
   Absent: None (0)

   THE MOTION CARRIED UNANIMOUSLY.

VI. Closed Meeting Items

   A. Report from Director of Internal Audit
   B. Discussion of Personnel Matters

   Director Gugenheim, seconded by Director Deer, 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.”

   On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

   Yeas:  Chair Koetting and Directors Deer and Gugenheim (3)
   Nays:  None (0)
   Absent:  Director Reiter* (1)

   THE MOTION CARRIED UNANIMOUSLY and the Committee convened into a closed meeting.

* Director Reiter was not present for the roll call vote to go into a closed meeting, but was present in the closed meeting.
Chair Koetting declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VII. Adjourn

As the agenda was exhausted, Chair Koetting declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXXXXX
Mike Koetting, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

There were no requests for follow-up made at the meeting.
Meeting Objectives

Review

Highlights of FY 2020

- Metrics
  - Year-Over-Year Comparison
  - Contacts by Category
    - Cook County Health System Compliance Program
    - CountyCare Medicaid Health Plan Compliance Program
      - Recoveries

- Receive and File – Annual Reports
  - Cook County Health System
  - CountyCare Compliance

Facing Forward – 2021 Compliance Work Plan
Metrics

Highlights of the Annual Reports
Year-Over-Year Compliance Program Contacts

Separating out CCH System Compliance and CountyCare Health Plan

- FY 2016: CCH (Provider) - 609, CountyCare - 149
- FY 2017: CCH (Provider) - 620, CountyCare - 176
- FY 2018: CCH (Provider) - 740, CountyCare - 125
- FY 2019: CCH (Provider) - 838, CountyCare - 307
- FY 2020: CCH (Provider) - 983, CountyCare - 337
FY 2020 Contacts by Category

CCH System Compliance Program

12/01/2019 – 11/30/2020

<table>
<thead>
<tr>
<th>Categories</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Privacy/Security (HIPAA)</td>
<td>378</td>
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<tr>
<td>Documentation</td>
<td>211</td>
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<tr>
<td>Regulatory/Policy</td>
<td>199</td>
</tr>
<tr>
<td>Human Resources</td>
<td>77</td>
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<tr>
<td>Contracts</td>
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<td>Conflict of Interest</td>
<td>20</td>
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<tr>
<td>Fraud Waste &amp; Abuse</td>
<td>16</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
</tr>
</tbody>
</table>

Total Contacts: 983

165 Contacts (17%) were COVID-19 Related
FY 2020 Contacts by Category

CountyCare Health Plan Compliance Program

12/01/2019 – 11/30/2020

Categories

<table>
<thead>
<tr>
<th>Categories</th>
<th>Count</th>
</tr>
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<tbody>
<tr>
<td>Privacy/Security (HIPAA)</td>
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<tr>
<td>Regulatory/Policy</td>
<td>62</td>
</tr>
<tr>
<td>Contracts</td>
<td>45</td>
</tr>
<tr>
<td>Fraud, Waste &amp; Abuse</td>
<td>97</td>
</tr>
<tr>
<td>Other</td>
<td>19</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>337</strong></td>
</tr>
</tbody>
</table>

12 Contacts (4%) were COVID-19 Related
## CountyCare Fraud, Waste and Abuse Recovery Metrics

### State Fiscal Year (S-FY) 2020 through S-FY 2021 Q2

<table>
<thead>
<tr>
<th>S-FY</th>
<th>Reporting Period</th>
<th>Tips</th>
<th>Referrals to HFS OIG</th>
<th>Overpayments Identified</th>
<th>Overpayments Collected</th>
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</thead>
<tbody>
<tr>
<td>2020</td>
<td>07/01-06/30/2020</td>
<td>207</td>
<td>7</td>
<td>$7,158,000</td>
<td>$5,370,000</td>
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<tr>
<td>2021</td>
<td><strong>Q1 07/01-09/30/20</strong></td>
<td>49</td>
<td>0</td>
<td>$1,277,500</td>
<td>$196,600</td>
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<tr>
<td>2021</td>
<td><strong>Q2 10/01 – 12/31/20</strong></td>
<td>106</td>
<td>8</td>
<td>$1,697,500</td>
<td>$304,000</td>
</tr>
</tbody>
</table>

1. 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.

2. The *Overpayments Identified* column indicates the total amount paid to the provider for the 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.

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**Cook County Health**
## CountyCare Mismanagement and Misconduct Recoveries

### State Fiscal Year (S-FY) Q1 and Q2 2021

**Retrospective Payment Integrity (Data Mining)**

<table>
<thead>
<tr>
<th>S-FY</th>
<th>Reporting Period</th>
<th>Data Mining Algorithms</th>
<th>Provider Count</th>
<th>Overpayments Collected</th>
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<tbody>
<tr>
<td>2021</td>
<td><strong>Q1 07/01–09/30/20</strong></td>
<td>40</td>
<td>66</td>
<td>$0</td>
</tr>
<tr>
<td>2021</td>
<td><strong>Q2 10/01–12/31/20</strong></td>
<td>40</td>
<td>10</td>
<td>$0</td>
</tr>
</tbody>
</table>

1 Recoupments permitted by HFS on 10/31/2020, notice to Benefit Administrators 11/2020, notice to Providers 12/2020, initial recoveries anticipated in February 2021.

### Proactive Preventative Loss

<table>
<thead>
<tr>
<th>S-FY</th>
<th>Reporting Period</th>
<th>Overpayments Collected</th>
</tr>
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<tbody>
<tr>
<td>2021</td>
<td><strong>Q1 07/01–09/30/20</strong></td>
<td>$333,400</td>
</tr>
<tr>
<td>2021</td>
<td><strong>Q2 10/01–12/31/20</strong></td>
<td>$716,000</td>
</tr>
</tbody>
</table>
Additional CountyCare Compliance Recoveries

Administrative Policies Not Followed

Failure of Benefit Administrator to Comply with Provider Payment Holds
  • Recovery: $180,400

Failure to Comply with Payment Holds for a Specific Code
  Qualified Medicare Beneficiary program code (QMB 09 Code)
  • Potential Recovery: $9,675,000
  • Actual Recovery: $6,689,000
Receive and File

Annual Reports
Corporate Compliance Annual Reports

CCH System Compliance Program and CountyCare Medicaid Plan Compliance Program
Facing Forward

FY 2021 Work Plan
Facing Forward

2021 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 2021,

• Implementation of a Corporate Compliance Program Effectiveness Evaluation
• Development of a Research Compliance Program
• Initiation of a Coding Integrity Program
• Enhancement of Corporate Compliance Training Materials
## Moving Forward

Independent External Compliance Program Effectiveness Evaluation

<table>
<thead>
<tr>
<th>TASK</th>
<th>TIMEFRAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiate engagement: Arrange for document request and scheduling</td>
<td>Day 1-14</td>
</tr>
<tr>
<td>Interviews. Provide document request for review and analysis</td>
<td></td>
</tr>
<tr>
<td>Begin document analysis; Scheduling of interviews</td>
<td>Day 15-45</td>
</tr>
<tr>
<td>Meetings, interviews, and additional document review</td>
<td>Day 46-60</td>
</tr>
<tr>
<td>Analyze findings, recommendations, prepare draft report</td>
<td>Day 61-75</td>
</tr>
<tr>
<td>Coordinate CCH Feedback; Report certification. Issue Final Report</td>
<td>Day 76-90</td>
</tr>
<tr>
<td>Formal Presentation if requested by CCH</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Questions?
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I. Executive Summary

The Fiscal Year (FY) 2020 CountyCare Compliance Program Annual Report summarizes the compliance activities carried out in FY 2020, as well as identifies priorities for FY 2021.

During this past fiscal year, CountyCare Health Plan, as a whole, accomplished many goals and implemented a variety of initiatives. The Cook County Health (CCH) Corporate Compliance Program dedicated to CountyCare was directly involved in each major initiative to assure the execution adhered to and incorporated relevant regulatory directives and contractual requirements. A few health plan achievements include:

- **CountyCare Remained the Largest Medicaid Health Plan in Cook County:** At the close of FY 2020, CountyCare remained the largest Medicaid Health Plan in Cook County for the third year in a row, as of January 4, 2021 the plan was covering 380,386 lives.
- **NCQA Rating:** CountyCare was named one of the top-rated Medicaid plans in Cook County by the National Committee for Quality Assurance (NCQA). CountyCare also completed its 3-year NCQA re-accreditation, with a perfect score on the technical survey.
- **COVID-19 Public Health Emergency:** CountyCare provided a comprehensive COVID-19 response, which included targeted member outreach, home delivered meals program, remote patient monitoring, delivery of member wellness kits, initiation of a flexible housing pool benefit, enhanced transportation, etc.

During the same timeframe, CountyCare Compliance accomplished several significant goals despite a number of hardships including diminished staffing levels in the department and the effects of the COVID-19 public health emergency (PHE). These include:

- **MCCN Agreement – New Amendments, Amendment #2 (KA2) and Amendment #5 (KA5).** Significant changes were made to the compliance related provisions of the Managed Care Community Network (MCCN) Agreement with the Illinois Department of Healthcare and Family Services (HFS). CountyCare Compliance, in collaboration with the System Corporate Compliance Program, reviewed and revised the CountyCare Compliance Plan, multiple CCH Compliance and CountyCare health plan policies and other written guidance documents to ensure alignment with the changes made to CountyCare’s contractual and legal requirements with the amendments, as well as best practices.
- **Collaboration with Special Investigation Units (SIUs) for Payment Integrity Initiatives.** CountyCare Compliance Program Integrity activities resulted in a total of approximately $5.397 million collected in overpayments in state Fiscal Year (S-FY) 2020, which was a 170% increase over the S-FY 2019 total of approximately $1.987 million. This increase occurred despite temporarily suspending routine record requests for certain audits at the outset of the PHE while continuing aggressive pursuit of intentional activity by providers that appear to be coding and/or billing fraudulently. This alternative plan was allowed by the HFS Office of Inspector General (OIG). This action slowed payment integrity
initiatives until October 2020 when HFS OIG and Bureau of Managed Care permitted CountyCare Compliance to resume recovery activities.

- **HFS OIG Compliance Attestation Completion.** In October of 2020, CountyCare Compliance gathered and submitted a substantial amount of information regarding the CountyCare Compliance Program structure, guidance and activities in response to an HFS OIG Compliance Program Review Self-Assessment Questionnaire. No feedback has been provided by HFS OIG.

- **Successful Health Services Advisory Group (HSAG) Audit:** CountyCare Compliance submitted a large volume of documentation to HSAG, the audit contractor used by HFS for its Managed Care Organizations (MCOs), with respect to review topics addressing Fraud, Waste and Abuse (Standard XIII) and Confidentiality (Standard IX). A virtual review of the health plan was conducted with remote interviews by HSAG on November 12-13, 2020. CountyCare Compliance scored 100% with respect to each of the audit standards reviewed, as reflected in the HSAG final audit report.

- **COVID-19 Public Health Emergency:** CountyCare Compliance provided continuous monitoring of the changing regulatory landscape in response to COVID-19, as related to the CountyCare comprehensive COVID-19 response (including targeted outreach, home delivered meals program, remote patient monitoring, enhanced transportation, etc.,), synthesizing significant regulatory changes and communicating guidance to operational leadership and vendors. Additionally, CountyCare Compliance was integral in monitoring updates communicated via HFS and HFS OIG related to efforts addressing fraud, waste, abuse, mismanagement and misconduct that were impacted by COVID-19.

In FY 2021, CountyCare Compliance will continue to focus on maintaining adherence to contractual requirements and healthcare compliance best practices, as both the health plan and compliance program mature. In collaboration with its delegated vendors, CountyCare Compliance will concentrate on identifying opportunities for risk reduction in the areas of compliance, policy implementation, and the development and implementation of monitoring and auditing efforts.

Notable priorities that have been identified for FY 2021 include:

- **Selection of a new designated Compliance Officer for the CountyCare health plan** (interviews planned for February 2021) and increased effort to locate additional resources for CountyCare Compliance to better concentrate on initiatives designed to improve the Compliance Program, Program Integrity, or compliance presence for CountyCare operations as a whole.

- **Increase CountyCare workforce education and knowledge regarding the Compliance Department’s duties, the compliance hotline, and a workforce member’s duty to report to encourage proactive identification and discussion of issues with the department.**

- **Strengthen processes for Program Integrity oversight in the areas of fraud, waste, abuse, mismanagement and misconduct, in collaboration with vendor partners.**

- **Identify and implement opportunities for collaboration with the health plan Delegated Vendor Oversight program to conduct annual compliance related audits of vendors.**
- Continue to work collaboratively with HFS, HFS OIG, non-government organizations and other MCOs’ SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.

II. 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). Since late 2012, CCH has partnered with the State of Illinois, initially through the State of Illinois federal Section 1115 demonstration waiver which was an early start on Medicaid expansion, then in 2014, CountyCare transitioned into the MCCN. The operation of the CountyCare MCCN is facilitated through CCH and its various subcontractors.

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, CCH developed and implemented the CountyCare Compliance Program.¹ The CountyCare Compliance Program is designed to demonstrate the health plan’s ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and the Code of Ethics.

This Annual Report presents the activities throughout county Fiscal Year 2020 (FY 2020). The CountyCare Compliance Program is under the executive leadership of Cathy Bodnar, Chief Compliance & Privacy Officer, who is also serving as the Interim Compliance Officer, CountyCare with the departure of the dedicated Compliance Officer for CountyCare in February 2020. In her Interim Compliance Officer, CountyCare role, the Chief Compliance & Privacy Officer is supported by Ashley Huntington, CCH Privacy Officer and other individuals within the CCH Corporate Compliance department. In the 4th Quarter 2020, the department also engaged a Senior Compliance Consultant and Compliance Consultant from Strategic Management, LLC to assist with critical CountyCare projects and temporarily fill staffing openings for the Corporate Compliance department.

III. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the structure and activities of the CCH Corporate Compliance Program generally, which includes the infrastructure to support a comprehensive compliance program for CountyCare and its affiliates.

¹ 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 HHIS OIG Compliance Guidance documents linked here.
Adequate resourcing for the CountyCare Compliance Program emerged as a significant issue area in FY 2020, beginning with the departure of the Compliance Officer, CountyCare in February of 2020. This position is still vacant, with the Chief Compliance & Privacy Officer currently filling the role of interim Compliance Officer, CountyCare. Additionally, due to the CCH budget staff reduction, the department was required to eliminate two Compliance Analysts positions. The least senior Compliance Analysts worked on the CountyCare Compliance team, they were eliminated in June of 2020. The department lost a third Compliance Analyst to resignation in November 2020. This Compliance Analyst on the CCH System Privacy team also remains open. Efforts to fill open positions are a priority for the department in FY 2021.

Due to significant staffing shortages, CCH Corporate Compliance engaged in interdepartmental workload redistribution, with emphasis on identifying CountyCare Compliance issues and/or responsibilities that could be performed temporarily by the CCH System Compliance team. The department also engaged longtime department consultants, Strategic Management, LLC to assist with critical CountyCare and Privacy projects and support the overall success of the Corporate
Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

Compliance Program. A Senior Compliance Consultant and Compliance Consultant from Strategic Management are currently providing staffing support for the department.

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

CountyCare Compliance Program Scope

The CountyCare Compliance Program is tasked with outlining guidelines and providing insight to:

- Comply with the CMS 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;
- Protect health plan members, providers, CCH, the State, and the taxpaying public from potentially fraudulent activities;
- Respond and provide guidance related to privacy, confidentiality, and security matters;
- Provide high level oversight to the health plan’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.

The following types of activities and issues fall into the CountyCare Compliance Program purview:

- Interpretation of contracts, laws, rules, regulations, and organizational policy as they relate to CountyCare Compliance;
- Accurate Books and Records;
- Conflict of Interest;
- Fraud, Waste, Abuse, Misconduct and Mismanagement; and
- Member Privacy, Confidentiality, and Security (HIPAA).

Further, the program 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 modalities;
- Responsibility to report potential and actual issues;
- Consequences of not reporting; and
- Non-retaliation protections.

The CountyCare Compliance Program scope of work is subject to ongoing review and revision as deemed necessary to ensure ongoing compliance. 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.

IV. COVID-19 Related CountyCare Compliance Activity

As with the countless other CCH departments, CountyCare Compliance was significantly impacted by the emergence of the COVID-19 pandemic and made internal shifts in its operations to allow for the flexibility of off-site work. Notably, the department was tasked with serving as a resource for the health plan to monitor, interpret, and provide guidance on the rapidly changing regulatory landscape, particularly as related to updates communicated from state agencies and departments (i.e., HFS and HFS OIG).

CountyCare Compliance received its first COVID-19 related contact on March 12, 2020. Since that time, the department responded to a total of 12 unique contacts related to COVID-19.

The chart to the right provides a breakdown of the issues reported, by category, where COVID-19 related questions were presented.

Examples of the types of essential topics addressed by CountyCare Compliance related to COVID-19 contacts include:

- Privacy and security concerns related to sharing and communicating member information, internally and with vendors and providers, for COVID-19 care management and care coordination related purposes.
- Communications for members and providers to accurately explain the CountyCare Task Force efforts and helpful COVID-19 related resources.
- Interpretation and impact of notifications received from state agencies to temporarily suspend routine record requests and other Special Investigation Unit (SIU) and Program Integrity activities during the COVID-19 crisis.
- Interpretation and impact of notifications received from state agencies regarding delays in implementation of various programs or initiatives that were set to roll out during FY 2020 (i.e., implementation of the Integrated Health Home program, Ordering, Referring, Prescribing (ORP) Provider edits).
- Explanations regarding Section 1135 waiver provisions addressing provider flexibilities, urgent appeals and Medicaid fair hearings during the public health emergency.
- Permissibility of providing health plan members with helpful resources, including Wellness Kits and enhanced plan benefits, during COVID-19.
While the COVID-19 related contacts account for approximately 4% of the total contacts received by the department, steps taken related to each of these issues were essential to ensure that health plan operations continued in line with state and federal regulator expectation. Additionally, the impacts of COVID-19 can be seen through much of the work reflected related to each element of the CountyCare Compliance Program, listed in Section V. below. CountyCare Compliance anticipates providing significant ongoing support on COVID-19 related issues well into FY 2021.

V. Annual Compliance Program Activity – Performance of the Elements

This section of the report serves to summarize activities performed by CountyCare Compliance in FY 2020 and demonstrate the effectiveness of the program, using the seven (7) Compliance Program Elements for a comprehensive compliance program as criteria, as outlined in the CMS Managed Care Program Integrity requirements and by contractual provisions in the MCCN Agreement.²

**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 fraud, waste, abuse, mismanagement or misconduct.

The CCH Code of Ethics applies to all CountyCare personnel, 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 and sub-regulatory guidance and contractual requirements. CountyCare also maintains a Compliance Plan that outlines demonstrate 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.

**Policies and Procedures**

CountyCare Compliance, in collaboration with System Corporate Compliance, engaged in the following activities impacting written guidance to promote and maintain an effective compliance program for the CountyCare Health Plan:

- Reviewed and revised the CountyCare Compliance Plan and multiple CCH Compliance and CountyCare health plan policies to ensure alignment with the significant changes made to CountyCare’s contractual and legal requirements, particularly the Program Integrity related requirements outlined in the MCCN Agreement, Amendment 2 (KA2), as well as best practices.

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• Developed additional CountyCare Compliance internal policies and procedures related to processes for reporting fraud, waste, abuse, mismanagement and misconduct to HFS OIG, as well as the process for handling Provider Alerts and fulfilling data requests received from HFS OIG.

• Conducted annual audit of CountyCare’s delegated vendors to ensure adherence to CountyCare’s policies and procedures, as well as the new MCCN contractual requirements addressing Program Integrity.

• Reviewed, revised and continued to abide by the CountyCare Compliance Plan that specifically outlines the compliance responsibilities of the health plan and program design, as well as specific CountyCare compliance policies for high risk areas focused on health plan operations.

• Ensured that 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/or drafted appropriate compliance contract language for new or updated CountyCare contracts with delegated vendors and providers.

Ad Hoc Activities/Guidance

CountyCare Compliance, in collaboration with System Corporate Compliance, worked with operational areas to assess compliance with policies, procedures and/or regulatory requirements and, in certain instances, assisted in the development of new policies, procedures and guidance.

Examples of areas assessed:

• **MCCN Contract Amendments (KA2 and KA5) Changes:** Contract Amendment 2 (KA2) related to the Program Integrity raised many questions regarding how to implement particular sections. CountyCare Compliance actively reached out to other MCOs, gathered questions, and presented to HFS OIG for clarification.

• **Medical and Prior Authorization Policies:** Continued to work with CountyCare Special Investigation Units (SIU) to identify areas where prior authorization processes or claims edits could reduce waste, abuse, mismanagement and misconduct for the Medicaid program.

• **Provider Manual:** Updated the Member Handbook to strengthen language and to reflect updates to fraud, waste and abuse language based on the MCCN Amendment 2 (KA2).

• **Recipient Restriction (Lock In) Program:** Analyzed, provided guidance and reviewed draft policies and procedures addressing Recipient Restriction Program processes, including how members are enrolled, communications made to members/providers regarding lock in changes and the process for monitoring program progress to CountyCare Pharmacy and Quality departments.
• **Documentation Standards for Health Records Policy:** Communicated with SIUs to research and establish requirements related to provider signature requirements, cloning occurrences in medical records and extender billing.

• **Provider Preventable Conditions:** CountyCare Compliance collaborated with the Chief Medical Officer and the health plan’s third-party administrator (TPA) to develop policies and procedures related to provider preventable conditions. The policies were implemented as the TPA made configuration and analysis delivery available.

• **Flexible Housing Pool Benefit:** CountyCare Compliance, the Privacy Officer, Cook County Health, Director of Clinical Services, CountyCare and other CountyCare clinical staff collaborated to outline parameters for how to structure and implement a flexible housing pool benefit for health plan members, including how to properly share information across vendors and partners taking consideration current privacy related contract constraints and minimum necessary requirements.

• **MoreCare Medicare Guidance:** CCH, through its Health Plan Services department, continues to partner with MoreCare to operate a Medicare product. Compliance continues to collaborate with MoreCare Compliance to provide guidance to staff working on both the Medicaid and Medicare businesses regarding the differences in Medicare and Medicaid program requirements and the continued need to segregate CountyCare data from MoreCare data and utilize access controls to maintain appropriate protection of data.

• **System Access Tracker:** Worked with the CountyCare workforce to continue implementation of a process to monitor system access separate and distinct from CCH systems access. The CountyCare workforce has access to multiple external resources that contains sensitive information including member protected health information, by example through TPAs. A policy and procedure was developed to safeguard member protected health information and confidential material and education was provided to CountyCare workforce.

• **Vendor Data Requests:** CountyCare Compliance collaborated with health plan operations to ensure that new vendor contracts specifically address the expectation that vendors will handle data requests once the contract ends, and their responsibilities related to historical data transferred from the prior vendor.

**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, responsible for developing and implementing policies and procedures designed to ensure compliance with program integrity requirements. Oversight for 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
Cathy Bodnar, the Chief Compliance & Privacy Officer, reports to both the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors. The graphic below illustrates the communication and reporting structure for the CountyCare Compliance program, which is embedded within the CCH Corporate Compliance Program.

For the first part of FY 2020, Elizabeth Festa, Compliance Officer, CountyCare assisted the Chief Compliance & Privacy Officer in the operation of the CountyCare Compliance Program. However, with the departure of the Compliance Officer, CountyCare in February of 2020, the Chief Compliance & Privacy Officer assumed the primary operational responsibility for CountyCare Compliance in her capacity as interim Compliance Officer, CountyCare.

For FY 2020, the primary duties of the Compliance Officer, CountyCare continued to include the following:

- Governance of the Health Plan's Fraud, Waste, Abuse (FWA), Mismanagement and Misconduct Program (Program Integrity Program) and Special Investigations Units to ensure that Program Integrity efforts are actively administered.
- High level oversight of the Health Plans' complaint, grievance, appeals and the fair hearing processes for program compliance, including review of trends and patterns through reports and data analysis.
Ensures that Program Integrity issues are reported in accordance with federal, state and local requirements, as well as the guidelines in the Medicaid Managed Care regulations at 42 CFR §438.608 and the CCH MCCN Agreement with HFS.

Implements and coordinates communication channels to encourage workforce, employees and independent contractors to report issues related to noncompliance and potential Program Integrity issues without fear of retaliation.

Reviews health plan agreements, contracts, addenda, and other relevant documents, as needed.

Aligns with operational management of the Health Plans' sanction/exclusion check to ensure that providers, management, workforce and independent contractors (where necessary) are screened against applicable Federal and state sanction and exclusion lists.

Coordinates potential Program Integrity investigations/referrals with the SIU, where applicable.

Partners with other health plans, HFS, HFS OIG, Medicaid Fraud Control Units (MCFUs), commercial payers, and other organizations, where appropriate, when a potential FWA issue is discovered that involves multiple parties.

Collaborates with operational leadership to facilitate operational ownership of compliance.

Synchronizes system-wide compliance program materials and messaging to present a uniform approach.

Oversees, directs, delivers, tracks, or ensures delivery of compliance training, both global and specialty, for employees, providers, volunteers, students, vendors, and consultants.

Develops, assesses, evaluates, implements, maintains, and updates compliance policies and procedures to ensure adherence with relevant requirements.

Establishes a structured process for regulatory review, monitoring, and dissemination of information.

Modifies policies, procedures, and projects to reflect changes in laws and regulations.

Develops and coordinates compliance projects with CCH system entities and performs prospective reviews in conjunction other personnel as deemed necessary.

Assures that Compliance Program reports are produced for the Chief Executive Officer, Board of Directors, and the Audit and Compliance Committee of the Board of Directors.

The following committees are tasked with oversight over the CountyCare Compliance Program, as outlined below:
• The **Audit & Compliance Committee of the Board** meets quarterly and 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 Audit & Compliance Committee of the Board receives periodic updates regarding the CountyCare Compliance program, including Fraud, Waste and Abuse (FWA) metrics and assessments of risk areas.

• The **CountyCare Regulatory Compliance Committee**, chaired by the Compliance Officer, CountyCare, meets quarterly and 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 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 Committee reports through the Chief Compliance and Privacy Officer to the Audit & Compliance Committee of the Board.

Additionally, the Compliance Officer, CountyCare participates in the following regular committees and/or Program Integrity related meetings in order to fulfill their responsibilities as a senior executive within the health plan operations:

• The **CountyCare Executive Committee** is comprised of CCH senior delegates and CountyCare leadership and is responsible for providing oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider-sponsored organization. The Committee provides useful feedback to CountyCare leadership regarding Plan performance and promotes alignment between CCH objectives and CountyCare programs. The meeting scope and schedule is currently under re-evaluation by executive leadership considering the COVID-19 impact to operations.

• The **HFS OIG MCO Subcommittee** is 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 fraud, waste and abuse activity as it relates to specific providers and trends.

• Corporate Compliance **Program Integrity Meetings** with delegated vendors occur on bi-weekly or monthly cadence, depending on the vendor and amount of activity. Led by the Compliance Officer, CountyCare, and attended by other members of the Corporate Compliance department, as needed, 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.
• **Medical Cost Action Plan** (MCAP) meetings with executive CountyCare leadership held monthly (or more often) to collectively identify and track opportunities for savings across health plan departments and initiatives.

• The CountyCare **Grievance and Appeals Committee** is a subcommittee of the CountyCare Quality Improvement Committee (QIC) and the CountyCare Regulatory Compliance Committee and is responsible for maintaining compliance with contractual, federal, and accrediting body requirements, including NCQA standards, related to the processing of grievance and appeals. The scope of the committee includes tracking and analysis of member grievances and appeals from all delegated vendors including type and timeliness of resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions as indicated.

• The **Delegated Vendor Oversight Committee** meets quarterly to provide oversight of the operations affecting the scope of functions of delegated vendors and subcontractors to ensure compliance with statutory and contractual requirements. The Committee also provides oversight of quarterly delegation audits, monthly joint operations meetings and regular monitoring of member and provider complaints. Identified areas of risk that fall under the purview of Corporate Compliance are referred to Corporate Compliance for assessment.

**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**

Traditional CountyCare Compliance related training opportunities were limited in FY 2020, due to the emergence of COVID-19 and the shift to remote, in-home work environments for the CountyCare workforce. However, CountyCare Compliance was able to participate in the following opportunities to present training related to Compliance, FWA and HIPAA.

1. **CountyCare – Provider FWA training and New Employee/Contractor Orientation**
   - Reviewed and updated provider Fraud, Waste and Abuse training to provide new content related to Program Integrity contract changes.
   - Participated in New Employee training, providing new hires (both permanent and contractual) an introduction to all aspects of CountyCare, with dedicated time for compliance program introduction.
2. **CountyCare – HIPAA Reminder Training**
   - Corporate Compliance was asked to present on the topic of privacy at CountyCare’s regular Lunch and Learn series. During this meeting, Compliance highlighted the basics of HIPAA, including the rules surrounding uses and disclosures of protected health information (PHI), as well as our responsibilities to protect member PHI. Compliance further discussed transport layer security (TLS) connections between CountyCare and its business partners. Finally, systems access was highlighted and staff were introduced to the CountyCare Systems Access Tracker.

3. **Targeted Education**
   - Reviewed the new MCCN Amendments (KA2 and KA5) for CountyCare training requirements and responsibilities and compared training materials submitted by TPAs and other delegated vendors to ensure compliance.
   - Provided guidance and commentary regarding updates to 42 CFR Part 2 related to the disclosure of substance/alcohol abuse records.

**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**

1. Several lines of communication are available for reporting issues and complaints related to CountyCare. Specifically, CountyCare Compliance:
   - Maintained an e-mail address for department Compliance communications (countycarecompliance@cookcountyhhs.org)
   - Monitored TPA’s support and assistance to CountyCare members through the TPA’s hotline service. Met bi-weekly with TPA’s compliance staff to discuss issues received through the hot line and appropriate responses to those issues.
   - Shared the accessibility of reporting concerns to the CountyCare workforce through:
     - A hotline service by a third party to preserve anonymity if desired;
     - A separate toll-free number for privacy breaches; and
     - Open door policies for Corporate Compliance leadership and each team member.
   - Established relationships and engaged internal and external resources to assist with investigations.
   - Identified trends and patterns to mitigate organizational risks and facilitate operational improvement.
• Presented trends and patterns to the CountyCare Compliance Committee, CountyCare Executive Committee, Audit & Compliance Committee of the Board, and the Managed Care Committee of the Board.

2. There are established CountyCare Compliance processes for responding to issues and complaints received. CountyCare Compliance maintains processes for issue, complaint management, and resolution as follows:

• The workflow process for compliance contacts follows SBAR, an acronym for Situation, Background, Assessment, and Recommendation.

• Initially, Corporate Compliance is made aware of a Situation,
  o Contact is made through one or multiple modalities e.g., via direct phone call or call through the compliance hot line, e-mail, and/or in-person;
  o An inquiry is made, or a concern is described;
  o An individual(s), area(s) or situation is identified.

• This Background information is classified, compiled and logged in the Corporate Compliance tracking tool.

• An Assessment occurs,
  o Reviewed and followed contractual obligations, organizational policy, federal, state, and county regulations related to the incident to evaluate the situation presented;
  o Determine what the problem is and/or the severity.

• Lastly, the Recommendation,
  o Establish a pathway for mitigation and remediation. These may include further auditing of documentation, mitigating harm, and potentially informing the appropriate government entity.
  o This always involves engaging and collaborating with leadership and appropriate entities.
  o Share recommendations with the reporter, as appropriate.

3. Categories have been defined to allow CountyCare Compliance to accurately organize and report compliance inquiries/issues received. The inclusion of an item in a specific category does not substantiate the issue; rather it classifies the issue within a defined category. The issues addressed within the past fiscal year of CountyCare Compliance addressed the following categories:

• Contractual Issues & Reviews;
• Regulatory/Policy Matters;
• HIPAA Privacy, Confidentiality and Security;
• Accurate Books & Records;
• Fraud, Waste and Abuse;
• Quality/Patient Safety
• Conflict of Interest; and
FY 2020 CountyCare Compliance Contact Volume

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

   337 contacts were documented for the CountyCare Compliance Program. The chart that follows illustrates the year-over-year activity, which shows a slight increase of 10% compared to the previous fiscal year.

![CountyCare Compliance Year-Over-Year Volumes](chart)

2. **Inquiry/Issue Breakdown by Category (December 1, 2019-November 30, 2020)**

![FY 2020 CONTACTS BY CATEGORY](chart)

The chart above illustrates the volume of FY 2020 contacts received by CountyCare Compliance, separated out by issue category. The associated category count follows,

<table>
<thead>
<tr>
<th>Categories</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIPAA - Privacy, Confidentiality and Security</td>
<td>114</td>
</tr>
<tr>
<td>Fraud, Waste, Abuse</td>
<td>100</td>
</tr>
<tr>
<td>Regulatory/Policy</td>
<td>61</td>
</tr>
<tr>
<td>Contracts/Agreements</td>
<td>45</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
</tr>
</tbody>
</table>
Issue types included in the “Other” category include queries regarding: documentation, conflict of interest, quality/member safety, human resources and others.

3. **FY 2020 Proactive vs. Reactive**

Of the 337 CountyCare contacts in FY 2020, 23% or 76 contacts, were proactive while 77% or 261 contacts were reactive.

Proactive contact is optimal because individuals seek guidance prior to the occurrence of an event or activity rather than retrospectively.

CountyCare Compliance looks forward to increasing awareness of CountyCare Compliance so that issues can be addressed in a more proactive manner in the coming year, where appropriate resources are available.

4. **Privacy, Confidentiality and Security (HIPAA)**

As a covered entity and business associate of HFS, the health plan is required to safeguard privacy for plan members. Privacy and security of member information is highly regulated, and this category accounted for 114, or 34% of all issues handled by CountyCare Compliance, in collaboration with the Privacy Officer, Cook County Health and other individuals within the CCH Corporate Compliance department.

During FY 2020, twenty-three (23) HIPAA related incidents were reported to CountyCare Compliance. Four (4) of the incidents were reportable breaches that required notifications to members. All four breaches occurred in relation to activities performed by CountyCare business associates. Each of the business associates confirmed that they provided additional training to their employees involved in these breaches.

Three (3) of the four (4) reported breaches involved mis-directed communications sent to the wrong individual (for example, mailing a prior authorization letter to the incorrect health plan member or leaving a telephone message for an individual who was not the intended recipient). In all three cases, Corporate Compliance notified the member impacted of the mistake, along with the Office for Civil Rights at the Department of Health and Human Services and HFS.

The fourth breach involved an impermissible disclosure of five (5) CountyCare members’ protected health information to a parent by a subcontractor’s Care Coordinator. Compliance
notified the five (5) affected members, along with the Office for Civil Rights at the Department of Health and Human Services and HFS.

Of the remaining HIPAA incidents, nine (9) of the nineteen (19) incidents were misdirected communications sent to another covered entity (hospital or care management entity, for example). The other ten (10) incidents involved technological and administrative errors, by example, a spreadsheet sent to correct business associate but contained more members than were requested.

Additionally, sixty-six (66) of the contacts included within the HIPAA category reflect activities related to reviewing and processing record requests for CountyCare health plan member records as related to subpoenas and subrogation matters that were carried out by CountyCare Compliance, with support from the CCH Corporate Compliance department.

Finally, twelve (12) contacts within the HIPAA category reflected guidance or review activities provided by the Compliance Officer, CountyCare and/or the Privacy Officer, Cook County Health, to confirm permissible instances of access, use or disclosure of member protected health information by organizational staff and benefit administrator/vendor partners.

5. Fraud, Waste, Abuse, Mismanagement and Misconduct

A significant amount of time and effort are assigned to the prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct by CountyCare Compliance. Of the 337 CountyCare contacts in FY 2020, 30% or 100 contacts, were related to fraud, waste, abuse, mismanagement and misconduct. More information regarding the health plan’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 also contractually obligated to have a system in place to receive and respond to various types of communications received from HFS OIG, received both on a regular basis (i.e., 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 Practitioners, (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 FY 2020 from HFS OIG, which CountyCare Compliance then communicated to its relevant SIUs and benefit administrators, as appropriate:
Additionally, HFS OIG communicates official data requests for information on an ad hoc basis, which generally require CountyCare Compliance to collaborate with its various SIU units, depending on the type of provider that is the focus of the request, to obtain and submit claims data, provider contracts, provider investigation or audit information, or communications made to a specific provider. During FY 2020, CountyCare received and responded to 51 requests for information submitted by HFS OIG.

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 FY 2020, CountyCare Compliance exercised and broadened the scope of its enforcement standards through:

- **Investigations and Guidance for Employee Related Corrective Actions.** CountyCare Compliance, via the Corporate Compliance department, 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 Plan (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 FY 2020, Corporate Compliance monitored four (4) vendors for improvement based on a CAP, DAP or PIP.

- **Privacy and Security (HIPAA) Breach Assessments.** CountyCare Compliance continues to work in collaboration with the CCH Privacy Officer to maintain consistency in
approach for breach assessments and to provide guidance to CountyCare workforce members and business associates.

- **Fraud, Waste, Abuse, Mismanagement and Misconduct Monitoring.** CountyCare Compliance collaborated closely with the Special Investigation Units of Delegated Vendors to identify potential fraud, waste, abuse, mismanagement and misconduct. CountyCare continues to work with its delegated SIUs to perform data analytics, including DRG auditing and coding analysis, in order to identify, investigate and report aberrant behaviors by providers, which includes processes for reaching out to providers to educate on issues identified as well as suggesting network termination for non-compliance with network provider agreement provisions, where appropriate.

- **Partnerships with Governmental Agencies.** CountyCare Compliance partnered with the HFS, HFS OIG, and Illinois’ Medicaid Fraud Control Unit (MFCU).

- **Partnerships with non-Governmental Agencies.** CountyCare Compliance continues to collaborate with a number of organizations related to the detection of fraud and wrongdoing in the insurance industry. These non-governmental organizations include other managed 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, HCCA (Health Care Compliance Association).

**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 is a central responsibility for CountyCare Compliance. Benefit and Program Integrity is critical not only because it is a contractual requirement and a significant focus by the State and Federal government but because it is the right thing to do. The impetus of this key initiative is to ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, abuse, mismanagement and misconduct in addition to protecting health plan members and providers.
To identify potential fraud, waste, abuse, mismanagement and misconduct, CountyCare Compliance partners with each delegated vendor through their dedicated areas commonly known as Special Investigation Units (SIU).

As reflected in the adjacent organization chart, the Compliance Officer, CountyCare provides direct oversight of program integrity activity.

**Auditing and Monitoring Efforts for FY 2020**

**Fraud, Waste, Abuse, Mismanagement and Misconduct**

CountyCare Compliance relies upon the monitoring, auditing, investigation, surveillance 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 Corporate 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 aberrant billing patterns and reviews. CountyCare Compliance also investigates tips received from HFS, HFS OIG, other Managed Care Organizations (MCOs), healthcare fraud groups, CountyCare employees, the media and other sources to identify fraud, waste, abuse and financial misconduct.

All Program Integrity activity is tracked by State Fiscal Year (S-FY) for state reporting purposes and not by county fiscal year. The S-FY runs from July 1st through June 30th.

Metrics for both S-FY 2020 along with the first two (2) quarters of S-FY 2021 follow:

<table>
<thead>
<tr>
<th>S-FY 2020 Total</th>
<th>Tips3</th>
<th>Referrals to HFS OIG4</th>
<th>Overpayments Identified5</th>
<th>Overpayments Collected6</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/01 – 06/30/19</td>
<td>207</td>
<td>7</td>
<td>$7,157,985.25</td>
<td>$5,369,934.89</td>
</tr>
</tbody>
</table>

3 The term tip, as defined by HFS OIG, includes as any allegations or incidents of suspected FWA opened on a CountyCare provider by the health plan. Often, tips reported to HFS OIG on a monthly basis 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.)

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

5 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.

6 Overpayments Collected represents the dollar amount recovered from the provider/group, as allowable by the MCCN Agreement.
The results of the annual Program Integrity activities are reflected in the metrics above with a total of $5,396,934.89 collected in overpayments in S-FY 2020. The amount recovered in S-FY 2020 was a 170% increase over the $1,986,699.41 recovered in S-FY 2019. This increase occurred despite temporarily suspending routine record requests for certain audits at the outset of the PHE. This action slowed payment integrity initiatives until October 31, 2020 when HFS OIG and Bureau of Managed Care permitted CountyCare Compliance to resume recovery activities. HFS OIG reiterated the department must receive a request from the health plan prior to initiating any recoupment from a provider.

CountyCare Compliance continuously monitors the process to ensure that appropriate action was taken, including reporting of suspected FWA to HFS OIG. In S-FY 2020, CountyCare referred 7-cases to the HFS OIG for possible fraud, waste, abuse, mismanagement or misconduct.

- **Annual Compliance Attestation**
  CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare’s delegated vendors in June 2020. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, including distribution of a Code of Ethics, FWA policy distribution, training and education requirements, sanction screening checks, offshore activity and delegated oversight.

- **Grievances and Appeals Activities**
  CountyCare Compliance continues to provide high-level oversight related to grievance and appeals activities at the plan level. Guidance and assistance is provided related, as needed, particularly related to contractual and regulatory timeframes. Additionally, CountyCare Compliance participates in the quarterly CountyCare Grievance and Appeals Committee, as well as Delegated Vendor Oversight meetings, where scheduling allows. The responsibility for State Fair Hearing activity transitioned from Corporate Compliance to CountyCare Utilization Management in FY 2019.

**Regulator Audit Activity for FY 2020**

CountyCare Compliance, in collaboration with Corporate Compliance department staff, submitted comprehensive documentation in response to two (2) sets of audit requests issued by HFS OIG and HSAG during FY 2020.

- **HSAG 2020 Evaluation of Administrative Processes & Compliance**
  In September of 2020, 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 November 12-13, 2020. HSAG recently communicated, via its final audit report, that CountyCare Compliance scored 100% with respect to each of the audit standards reviewed during the 2020 audit.

- **HFS OIG Compliance Program Review Self-Assessment Questionnaire**
  In October of 2020, a substantial amount of information regarding the CountyCare Compliance Program structure, guidance and activities was submitted in response to an HFS OIG Compliance Program Review Self-Assessment Questionnaire. As of yet, no feedback has been provided by HFS OIG.

### Risk Assessment

The focus within CountyCare Compliance is prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct, in addition to other areas of risk identified in FY 2020. Risk assessment currently is a fluid exercise within CountyCare Compliance, performed on a consistent, ongoing 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 health plan operations and benefit administrators.

Where resources are available in FY 2021, CountyCare Compliance plans to initiate an annual risk assessment with executive leadership and key thought leaders nationally to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.

### Element 7

The 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 the 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 that is 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.
Data is provided on a monthly basis to CountyCare Compliance to verify that sanction screening checks were conducted for medical and behavioral health providers. CountyCare vendors are also required to attest, on an annual basis, 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 both monthly and quarterly reports to HFS OIG capturing its Program Integrity activities, particularly with respect to fraud, waste, abuse, mismanagement and misconduct identified that is related to providers/groups enrolled in the Illinois Medicaid program.

- **Monthly Tips Report.**
  On a monthly basis, CountyCare Compliance submits a Tips Report to HFS OIG, documented within an Excel document, which lists out any allegations or incidents of suspected FWA that has been opened by the health plan related to a provider within that past month which impacts the HealthChoice Illinois program. Tips reported are not designed to be a fully vetted referral to HFS OIG; rather, they are designed to help provide necessary information to HFS OIG and avoid delays that would impact appropriate law enforcement or administrative review/action even before an audit or investigation has fully vetted the allegation.

- **Quarterly FWA Report.**
  The MCCN Agreement also requires CountyCare Compliance to submit a quarterly fraud, waste and abuse report to HFS. This report, also known as the FWA Tool, must include all instances of suspected fraud, waste, abuse, mismanagement and misconduct, among other Program Integrity data requested, or indicate that there was no suspected fraud, waste, abuse, mismanagement and misconduct during that quarter. While the FWA Tool is not intended to include administrative billing issues or routine claim errors, a considerable amount of time has been spend clarifying with HFS OIG the types of Program Integrity related information that should be included within the report.

  CountyCare Compliance devotes a significant amount of time and effort to develop, review and submit these reports to HFS OIG, including comprehensive coordination and communication with the various SIUs to gather and validate the required Program Integrity related activity information and data during the time in question. With that in mind, as stated above, CountyCare Compliance and resources within the Corporate Compliance department collaborated to develop an internal policy outlining the parameters for developing, reviewing and submitting the required reports listed above to HFS OIG.
VI. Looking Ahead to 2021

In FY 2021, the Corporate Compliance Program will continue to focus on maintaining adherence to contractual requirements and healthcare compliance best practices as the program matures. As CountyCare relies heavily on delegated vendors, monitoring for adherence to CountyCare policies, contractual, and regulatory standards are critical to avoid sanctions and ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste and abuse in addition to protecting health plan 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.

These priorities have been established for the CountyCare Compliance Program:

- Selection of a new designated Compliance Officer for the CountyCare health plan (interviews planned for February 2021) and increased effort to locate additional resources for CountyCare Compliance to better concentrate on initiatives designed to improve the Compliance Program, Program Integrity, or compliance presence for CountyCare operations as a whole.
- Strengthen health plan oversight in the area of fraud, waste and abuse:
  - 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’ SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.
  - Strengthen the partnership with the transportation delegated vendor to scrutinize potential FWA.
- Conduct a comprehensive annual risk assessment with executive leadership and key thought leaders nationally to identify outstanding risks and challenges to meeting the standards of an effective health plan compliance program.
- Increase workforce education and knowledge regarding the Compliance Department’s duties, the compliance hotline, and a workforce member’s duty to
- Implement opportunities for collaboration with the health plan Delegated Vendor Oversight program to conduct annual compliance related audits of vendors.
- 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.
- Continue to investigate all issues/complaints brought to the attention of the Program.
- Uphold compliance with continuously changing contractual requirements and industry best practices as CountyCare continues as the largest Medicaid Managed Care Organization in Cook County.
- Serve as a compliance and privacy resource to the workforce and delegated vendors.
- Mature the CountyCare Compliance Program and continue to incorporate best practices to cultivate a culture of compliance throughout the health plan.
- Maintain CountyCare Compliance Program recognition locally and nationally.
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I. Executive Summary

The Fiscal Year (FY) 2020 Compliance Program Annual Report summarizes the primary compliance activities that the Cook County Health (CCH) System Corporate Compliance Program accomplished in FY 2020 and identifies priorities for FY 2021.

During this past fiscal year, the CCH Corporate Compliance Program accomplished various goals and implemented new initiatives despite a number of hardships including the effects of the COVID-19 Public Health Emergency (PHE) and staffing levels in the department. These achievements include:

- **COVID-19 Public Health Emergency**: Ongoing monitoring of the changing regulatory landscape in response to COVID-19, synthesizing numerous, significant regulatory changes and communicating guidance to operational leadership and clinical staff.

- **HIPAA Privacy Expertise**: Establishing a national presence as subject matter experts in the realm of privacy compliance by presenting at multiple conferences, panels, and podcasts.

- **Local Government Records Management**: Embarking on a revision of the Record Retention Schedule for Cook County Health that addresses current record retention regulatory requirements and assimilates categories for user-friendly reference.

- **System-Wide Policy Committee Participation**: Incorporating Compliance into the multi-disciplinary team responsible for policy evaluations.

- **Accessibility**: On an ongoing basis, Compliance continues to respond to inquiries, allegations, and complaints in addition to monitoring these contacts for patterns and trends.

- **Consultation**: Providing ongoing compliance review and guidance as a member of several multi-disciplinary Task Forces and Committees.

- **Dual Employment Survey**: Administering the FY 2020 survey to all CCH employees. This requirement is based on the Cook County Ethics Ordinance and is mandatory through CCH Personnel Rules and the Dual Employment Policy.

In FY 2021, Corporate Compliance plans to continue serving as a resource for all workforce members within CCH. The department will collaborate with internal partners to assess the various risk areas and areas of potential non-compliance and work toward improving those areas.

Notable priorities for FY 2021 include:

- **CCH Compliance Program Evaluation**: Facilitating an external, independent effectiveness evaluation of the Compliance Program. Both the Department of Justice (DOJ) and HHS Office of Inspector (OIG) call for periodic assessments of compliance program effectiveness, stressing Programs should not remain static but continue to evolve and improve over time in response to the ever changing legal and regulatory environment.
Therefore, a key objective of the review will be to both verify and document strengths in the Compliance Program, but also seek opportunities where improvements and enhancements can be made.

- **Research Compliance Program**: Research is a heavily regulated environment, as such, having a Research Compliance Program in place is fundamental for ensuring compliance with the various laws and regulations from multiple agencies and enforcement bodies. The development of a Research Compliance Program can aid in identifying legal and regulatory problems, corrects deficiencies, and assist in preventing future problems.

- **Coding Integrity Program**: Accurate representation of a patient's clinical status is translated into coded data. These clinical codes have a systemic impact to the revenue cycle, organizational decision-making, clinical protocols, research outcomes and external reporting. The implementation of a Coding Integrity Program within Compliance adds additional structured oversight to monitor accuracy, facilitate improvements and strengthen reporting.

- **Compliance Education**: Refresh, renew, and rethink all compliance training materials including new employee orientation, annual education, and ad hoc refresher training.

- **Ongoing monitoring of regulatory changes**.

## II. Introduction

Cook County Health (CCH) System Corporate Compliance Program incorporates two (2) distinct Compliance Programs: encompassing CCH as a provider of health care services in addition to the public health department and the CountyCare Medicaid Health Plan with executive oversight of both programs by a Chief Compliance & Privacy Officer. In looking at the breadth of Compliance at CCH, system-level services occur within both CCH hospitals (John H. Stroger, Jr. Hospital of Cook County and Provident Hospital of Cook County), multiple outpatient clinics, correctional medicine at the Cook County Jail and Juvenile Temporary Detention Center, and the Cook County Department of Public Health. It also includes providers, clinicians and others that provide direct care to patients, in addition to workforce members not directly involved in patient care. In an indirect way, Corporate Compliance also encompasses all of CCH’s “business associates” – parties who have contracted with CCH and have access to our patients’ and members’ protected health information in varying capacities.

Although the CountyCare Medicaid Health Plan’s Compliance Program is addressed through a separate annual report, both programs are organized to function at the overarching organizational level and are designed to promote a culture of compliance within CCH as a whole. Corporate Compliance has outlined and enforced the expectation that all workforce members are responsible for prevention, detection, and reporting of instances that may not comport with state, federal, or local law, or CCH policy.

The Annual Report presents the activities throughout the county fiscal year 2020 (FY 2020) of the System Corporate Compliance Program under the executive leadership of Cathy Bodnar, Chief
Compliance & Privacy Officer, with support by Dianne Willard, Compliance Officer, Ashley Huntingon, Privacy Officer, Compliance Analysts and other external compliance resources to assist with critical projects and temporarily fill staffing openings.

This report also serves to demonstrate the effectiveness of the compliance program by looking at infrastructure, communication strategy and the methods or channels of communication. In addition, this report provides an assessment of the CCH Compliance Program by examining the seven (7) Compliance Program Elements as recommended in the Department of Health and Human Services Office of Inspector General (OIG) Compliance Program Guidance publications. The System Compliance Program is designed to demonstrate the CCH’s ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, and regulations, as well as CCH policies, procedures, and the Code of Ethics.

III. Building Blocks – Program Infrastructure and Scope

The Annual Report begins with a look at the activities of the Program that incorporate efforts to foster an infrastructure that produces a comprehensive compliance program. The existing Departmental Organization Chart follows:

Compliance Organizational Chart
CCH Corporate Compliance experienced staffing shortages in FY 2020. The Compliance Officer supporting CountyCare operations resigned in February 2020. This position remains open, with a first round of interviews occurring at the end of FY 2020. A second round of interviews with a new pool of candidates is scheduled to begin in early FY 2021. Additionally, due to the CCH budget staff reduction, the department was required to eliminate two Compliance Analysts who worked on the CountyCare Compliance team. The department lost a third Compliance Analyst, who worked under the Privacy Officer, to resignation in November 2020. This position remains open.

Due to the significant staffing shortages described above, Corporate Compliance engaged in interdepartmental workload redistribution, with emphasis on CountyCare Compliance issues being redistributed to the CCH Compliance team. The department also engaged longtime department consultants, Strategic Management, LLC to assist with critical CountyCare and Privacy projects and support the overall success of CCH Corporate Compliance.

Corporate Compliance once again partnered with the Department of Human Resources to offer internship opportunities for masters-level and law school students. Corporate Compliance welcomed two interns during FY 2020. One, a Masters-level student from Governors State University, worked with the Compliance Officer. This student engaged in compliance issues and projects including: compliance oversight of the registration process, new COVID-19 coding regulations and guidance for family planning based on regulatory changes. The second student was a law student from Loyola University Chicago School of Law. This student spent time working with the Privacy Officer on issues related to: privacy breaches, privacy requirements for mental health information and substance use information, reviewing system level contracts for privacy concerns, and how to implement effective privacy training.

**Corporate Compliance Program Scope**

Corporate Compliance continued to serve as a subject matter expert in many areas in FY 2020. CCH activities that fall into the Corporate Compliance purview include:

- Interpretation of federal, state, and local laws, rules, and regulations;
- Creation and maintenance of the CCH Code of Ethics along with Corporate Compliance policies and procedures;
- Investigation of allegations of inaccurate books and records including but not limited to merged medical records;
- Evaluation and guidance on potential conflicts of interest;
- Review of certain contracts/agreements, including business associate agreements, data use agreements, research, clinical trials, and grants, and compliance provisions of master service agreements;
- Assessment of compliance and policy guidance for the Emergency Medical Treatment and Labor Act (EMTALA);
- Watchdog for Fraud, Waste, Abuse and Financial Misconduct;
- Identification of risk through auditing and monitoring;
- Monitor for integrity in marketing and purchasing practices; and
- Safeguard privacy, confidentiality, and security under the Health Insurance Portability and Accountability Act (HIPAA) and related privacy and confidentiality laws.
IV. COVID-19 Public Health Emergency (PHE) Related Activities

The story of FY 2020 would not be complete without discussing the COVID-19 PHE. As with countless other departments, CCH Corporate Compliance experienced significant impacts due to the emergence of COVID-19 – both in changing its own operations to allow for the flexibility of off-site work and in serving as a primary resource for the health system to monitor, interpret, and provide guidance on a rapidly changing regulatory landscape. Because of these adjustments, the department rose to the challenge of finding new, effective ways of being present for the organization.

Corporate Compliance received its first COVID-19 related contact on March 12, 2020. Since that time, the department responded to a total of 165 unique contacts related to COVID-19. A breakdown of the categories where COVID-19 related inquiries follows:

<table>
<thead>
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<th>Category</th>
<th>Count</th>
<th>Category</th>
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<tr>
<td>Regulatory/Policy</td>
<td>59</td>
<td>Human Resources</td>
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<td>Other</td>
<td>5</td>
</tr>
<tr>
<td>Documentation</td>
<td>8</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

As demonstrated above, Corporate Compliance received 75 unique contacts related to both COVID-19 and HIPAA. This accounts for 45% of the total contacts received by the department. Of these contacts, many related to the ways in which protected health information (PHI) can be used and shared during the pandemic.

Corporate Compliance provided guidance on the following essential topics:

- Privacy and security considerations and requirements when
  - conducting telehealth appointments;
  - using iPads to conduct virtual visits with end of life COVID-19 patients and their family members while in person visitation was temporarily prohibited;
sharing the PHI of COVID-19 patients with mayors, first responders, public defenders, media, and many others and whether such sharing is allowed under applicable regulations;

- communicating rules surrounding de-identification of data to allow sharing of COVID-19 related statistics;

- advising on privacy requirements of mobile and community-based testing sites; and

- COVID-19 related clinical research agreements involving the use, disclosure, storage, and transmission of research subjects’ PHI.

• Regulatory/Policy inquiries presented regarding

  - ongoing regulatory changes for coding/billing telehealth and telephone services;

  - opining on requirements for documentation of services conducted through telehealth in addition to providing guidance for documentation when a patient did not attend a scheduled telehealth visit; and

  - supporting communication between Health Information Management, Clinical Areas and Revenue Cycle to ensure compliant procedures.

Compliance anticipates providing support on COVID-19 related issues well into FY 2021.

V. Being Present – Communication – Fostering Transparency

Communication Strategy

As with previous years, Corporate Compliance worked toward its goal of establishing and maintaining visibility and accessibility to CCH workforce although a majority of the year occurred off-site for most patient support staff. The organizational compliance communication strategy has been to increase the CCH workforce awareness of the following topics:

- Accessibility of the Corporate Compliance and Privacy team;

- Availability through multiple modalities (in-person, e-mail, phone, hot line; electronic meetings);

- Compliance with the Code of Ethics;

- Responsibilities regarding Privacy, Confidentiality, and Security;

- Requirements to report potential/actual issues; and

- Zero-tolerance for retaliation.

With the emergence of COVID-19, Corporate Compliance also spent considerable time dedicated to increase the CCH workforce’s awareness of heightened privacy and security requirements, particularly during a time when the media, governmental bodies, and general public were seeking any and all information on the PHE.
Communication Channels

Within FY 2020, Corporate Compliance communicated the aforementioned topics utilizing multiple formats:

- E-mail communications, particularly to the Command Center to provide essential regulatory updates and guidance for CCH workforce;
- Organizational newsletters (System Briefs);
- New employee orientation – previously attended in person; however, in response to COVID-19, slides on Corporate Compliance, Confidentiality and Privacy (HIPAA) were developed by Compliance but presented by Human Resources;
- Annual education;
- Screen savers; and
- Attendance/presence at team meetings, serving on a number of committees and commencing facilitation of multi-departmental workgroups.

VI. Compliance Program Structure: Performance of the Elements

Element 1

*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.*

The CCH Code of Ethics applies to all CCH personnel, providers, agents and subcontractors. The Code of Ethics, as well as CCH’s policies and procedures, support the organization’s commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements and is reviewed on a regular basis.

Policies and Procedures

Developed, updated, and performed triennial reviews on multiple system policies related to general compliance, governance, and HIPAA as system-wide policies moved to a new software platform. Functioned as a reviewer for numerous organizational policies with compliance, privacy, and/or security elements.

As a key stakeholder on the CCH Policy Review Committee, Compliance provided regulatory guidance and leadership to ensure policies were uniform throughout the organization. In FY 2020, Compliance reviewed 165 system-wide policies through the Policy Review Committee.
Work Plan Activities

In addition to policy and procedure activity, Corporate Compliance worked with several operational areas to assess compliance with regulatory requirements and procedures to provide guidance on steps to move forward toward meeting each requirement. Below is an overview of notable activities:

- Developed and facilitated a multi-departmental workgroup entitled, “Avoiding Tangled Records Task Force”
  - This task force was created to resolve tangled medical records found while conducting investigations and monitoring activity. This also led to amending the process for registering patients. In addition, re-education occurred for merging/unmerging records, and amending Patient Access and Health Information Management policies. At the end of FY 2020 the ownership of the Task Force transitioned to CCH operations.

- Tackled Responsibilities Set by Local Government Records Management
  - Initiated review of the Record Retention Schedule for Cook County Health that addresses current record retention regulatory requirements and assimilates categories for user-friendly reference. As a government entity, all documents must be reviewed to determine if they are considered “public records.”
  - CCH follows an approved Application for Authority to Dispose of Local Records, known as the Record Retention Schedule. The Schedule dates back to 1985, it contains 1,237 pages with 4,395 listed records and the associated retention periods.
  - Compliance conducted an organization-wide inventory and determined records to be maintained and the duration for which they are currently maintained. Compliance took under consideration federal, state, and local retention requirements, the recommendations of accreditation and professional organizations, the impact of the records on continuity of patient care and system operations along with the likelihood of future utilization retrieval of stored records.
  - This activity will result in an updated Record Retention Schedule for CCH.

- Partnered with the Office of General Counsel, Healthcare Information Systems (HIS), and the Office of Programmatic Services & Innovation
  - Collaborated with the aforementioned departments to establish a review and approval process for clinical research at CCH. This partnership included weekly status updates, review of clinical trial agreements, meetings with study sponsors,

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1 A "Public Record" means any book, paper, map, photograph, born-digital electronic material, digitized electronic material, electronic material with a combination of digitized and born-digital material, or other official documentary material, regardless of physical form or characteristics, made, produced, executed or received by any agency or officer pursuant to law or in connection with the transaction of public business and preserved or appropriate for preservation by such agency or officer, or any successor thereof, as evidence of the organization, function, policies, decisions, procedures, or other activities thereof, or because of the informational data contained therein. Found at https://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=699&ChapterID=11
and guidance to researchers on system compliance requirements for conducting research.
  o This partnership was especially important throughout COVID-19 as a number of COVID related studies were presented for review. Compliance reviewed 14 unique studies related to COVID-19.

• **Trained and Educated through the online Learning Management System**
  o Functioned as subject matter expert for three (3) mandatory education modules, Code of Ethics, Fraud, Waste and Abuse and Privacy. Modules are reviewed annually to assure compliance with regulatory and contractual requirements.

• **Facilitated Annual Dual Employment Surveys**
  o Pursuant to Cook County’s Ethics Ordinance, CCH Dual Employment Policy and Article 12 of CCH’s Personnel Rules, all employees must complete a survey annually whether or not the employee engages in any outside activity.
  o The application requires attestations by each employee for compliance with the Dual Employment policy and the Conflict of Interest policy.
  o This is the second year utilizing the existing CCH Salesforce software application.

**Element 2**

*The designation of a Chief Compliance Officer and other appropriate bodies, e.g., a corporate compliance committee, charged with the responsibility of operating and monitoring the compliance program, and who reports directly to the CEO and the governing body.*

**Compliance Office and Committees**

The graphic that follows illustrates the communication and reporting structure. Cathy Bodnar, the Chief Compliance & Privacy Officer, reports to the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors.
The primary duties of the Chief Compliance & Privacy Officer include the following:

- Provides oversight and guidance to the Board of Directors, Chief Executive Officer and senior management on matters relating to compliance.
- Monitors and reports results of organizational compliance/ethics efforts. Authorized to implement all necessary actions to ensure achievement of the objectives of an effective compliance program.
- Works in conjunction with the Privacy Officer to assure compliance with HIPAA and state laws regarding protection of patient and member health information.
- Monitors the performance of the Compliance Program and related activities, internally throughout CCH and externally for delegated entities, taking appropriate steps to improve effectiveness.
- Develops, initiates, maintains and revises policies, procedures and practices concerning Corporate Compliance for the general operation of CCH and its related activities including those to ensure compliance with the CCH Managed Care Community Network (MCCN) Agreement with Healthcare Family Services (HFS).
- Develops and periodically reviews and updates Code of Ethics to ensure continuing relevance in providing guidance to management and the workforce.
- Responds to alleged violations of rules, regulations, policies, procedures and the CCH Code of Ethics by evaluating or recommending the initiation of investigative procedures.
- Acts as an independent review and evaluation body to ensure that compliance issues/concerns evaluated, investigated and resolved, which may include reporting of violations or potential violations to duly authorized enforcement agencies as appropriate and/or required.
- Identifies potential areas of compliance vulnerability and risk; monitors operational corrective action plans for resolution of problematic issues, and provides general guidance on how to avoid or deal with similar situations in the future.
- Establishes and monitors a system to log, track and maintain documentation for all concerns/issues raised to Corporate Compliance.
- Institutes and maintains an effective compliance communication program for the organization, that includes (a) promoting the use of the compliance hotline or other mechanisms for communicating with Corporate Compliance; (b) emphasizing to leadership, employees, and workforce members reports of suspected fraud and other improprieties should be made without fear of retaliation; (c) heightening awareness of the Code of Ethics; and (d) understanding new and existing compliance issues and related policies and procedures.
- Works with CCH Human Resource Department and others as appropriate to develop, implement, maintain and document an effective compliance training program, including appropriate introductory training for new workforce members as well as ongoing training for all workforce members.
- Guides and partners with operational leadership to facilitate operational ownership of compliance. Consults with legal counsel, internal and external, as needed and independently to resolve difficult compliance issues.
• Collaborates with operational areas throughout the organization to direct compliance issues to appropriate channels for investigation and resolution.

The Audit & Compliance Committee 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.

In addition to the aforementioned relationships, the Chief Compliance & Privacy Officer receives support and guidance from the internal Corporate Compliance Executive Steering Committee, an assembly of executive leaders within CCH, including but not limited to, the CEO, Deputy CEO, System Director of Internal Audit, Chief Information Officer, Chief Medical Officer, Chief Nursing Officer and others.

Element 3
The development and implementation of regular, effective education and training programs for all affected employees.

Education and Training

1. New Employee Orientation
   Prior to the COVID-19 PHE, Corporate Compliance attended New Employee Orientation once every two weeks to present an “Introduction to Corporate Compliance and HIPAA. In response to the PHE, the Department of Human Resources requested departments develop material to address their respective areas. Corporate Compliance developed a presentation to address the subject matter routinely presented, Human Resources presents the material.

2. Targeted Education
   Prior to the PHE, Corporate Compliance worked with departments across CCH to provide targeted refresher training. Typically, this occurs either when a department leader requests training or when a HIPAA breach or incident occurs in a department and retraining is needed. Given the challenges with gathering in groups due to COVID-19, the departments and Corporate Compliance found it more effective to provide guidance in written form.

3. Annual Compliance Education
   As noted earlier, responsible for three (3) mandatory education modules, Code of Ethics, Fraud, Waste and Abuse and Privacy

Element 4
The maintenance of a process, such as a hot line, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect whistleblowers from retaliation.
Receiving and Responding to Complaints

Infrastructure Activities

1. Assisted our workforce members through:
   - A hot-line service provided by an independent, contracted third-party to preserve caller anonymity if desired. The individual is given a code number related to their report, and can call back or check the website using that code number to review comments and updates. In FY20, 68 calls or internet/online inquiries were received on the hot-line.
   - A separate toll-free number for patients and members to contact following notification of a privacy breach.
   - Collaboration with operational areas, including but not limited to General Counsel, Human Resources, HIS, Patient Relations, and Health Information Management (HIM) to assist in resolving compliance-related issues.

2. Maintained two e-mail addresses for departmentally,
   - Compliance (compliance@cookcountyhhs.org) and
   - Privacy (privacy@cookcountyhhs.org).

3. Engaged internal and external resources to assist in complex compliance and privacy research which, in the case of external resources, provided governmental and national perspectives on compliance issues.

4. Identified trends and patterns in enforcement actions to mitigate organizational risks and facilitate operational improvement, including:
   - Evaluating CCH’s status as a covered provider under 42 CFR Part 2.
     - Corporate Compliance worked with key clinical and administrative staff in the Medication for Addiction Treatment (MAT) program at CCH to assess compliance with privacy and confidentiality standards under 42 CFR Part 2.
   - Assisted a multi-disciplinary team to ensure that patients are billed for the correct Level of Care.
     - Corporate Compliance worked with a high level multi-disciplinary team to ensure that patients are being billed accordingly to the level of care provided, not the location of their bed. The Level of Care is monitored and modified based on the services provided. Compliance has provided regulatory guidance, and assistance in the revision of new report that generates the daily level of care throughout the hospital. Additionally, we have communicated the need for improved documentation of level of care within the electronic health records.
Collaborated with a multi-disciplinary team to create stream-lined process for Gift of Hope.
  o Provided regulatory guidance regarding documentation in electronic health record for organ donation. Assisted with implementation of a new order set that can be generated by Gift of Hope employees and worked with CCH Human Resources to modify badging and security access.

Provided compliance guidance and monitoring for the Sexual Assault Survivors Emergency Treatment Act (SASETA) Task Force.
  o Working with the Task Force to come into compliance with regulatory requirements for photo-documentation storage, retention, and access. In addition, provided guidance for new System-Wide Policies and Procedures.

Created and facilitated Avoiding Tangled Records Task Force.
  o Task force was created due to many registration errors discovered while conducting monitoring and during investigations. This task force led to creating and amending Patient Access and HIM policies to avoid tangled and merged records in the future. This also forced reeducation for many registration employees as part of the corrective action plan enforced by management.

Worked with HIM to create an Alias note type in the Electronic Medical Record.
  o In collaboration with HIM worked to ensure an Alias note type is created. This note allows HIM to explain any name discrepancies that may be found in patients’ electronic health records due to initial registration under an alias name.

Partnered with various departments worked on allegations of identity theft.
  o Upon patient’s receipt of a bill for services patient states one did not receive, Compliance worked together with Finance, Patient Relations, Clinic management, IT, and JSH Police to determine if the correct patient was treated and accurately billed under complainant’s identity and insurance. Ensured that payback was made to the appropriate payer accordingly to CMS guidance.

5. Presented trends and patterns to the CCH Compliance Executive Committee and the Audit and Compliance Committee of the Board.

General Processes for Responding to Inquiries, Issues and Complaints

The workflow process for compliance contacts follows SBAR, an acronym for Situation, Background, Assessment, Recommendation.

Initially, Corporate Compliance is made aware of a Situation,

- Contact is made through one or multiple modalities e.g., via direct phone call or call through the compliance hot line, e-mail, and/or in-person;
- An inquiry is made, or a concern is described;
- An individual(s), area(s) or situation is identified.
This Background information is classified, compiled and logged in the Corporate Compliance tracking tool.

An Assessment occurs,
- Research and review organizational policy, federal, state, and county regulations to evaluate the situation presented;
- Determine what the problem is and/or the severity.

Lastly, the Recommendation,
- Establish a pathway for mitigation and remediation. These may include further auditing of documentation, mitigating harm, and potentially informing the appropriate government entity.
- This always involves engaging and collaborating with leadership.
- Share recommendations with the reporter, as appropriate.

The work-flow process for potential HIPAA incidents and breaches similarly follows SBAR. However, if the Assessment determines a reportable breach has occurred then,
- HIPAA breach notification rules regulatorily require sending a notification letter to the affected individual(s) within sixty (60) days of discovery.
- Notification to the Office for Civil Rights (OCR) annually.

Breaches that affect over 500 individuals must include the following,
- Releasing a statement to prominent media outlets serving the state;
- Posting a notice on the CCH website; and
- Notifying the Office for Civil Rights (OCR) within sixty (60) days of discovery.

Similarly, collaboration with the operational area to determine and facilitate a corrective action plan which includes re-education.

The diagram that follows illustrates the approach to incident investigation and ensures that all the causes are discerned and addressed by appropriate actions.
Contact Volumes
In FY 2020, 983 identified contacts were documented for the CCH System Compliance Program. The chart that follows illustrates the year-over-year activity, which, despite substantial challenges from COVID-19 and staffing shortages, shows an increase of 17% compared to the previous fiscal year.

Contact Breakdown by Category
Categories defined below parallel the CCH Code of Ethics. The inclusion of a contact in a specific category does not substantiate the contact as a concern; rather it classifies the contact within a defined category.

In FY 2020, Corporate Compliance modified its internal tracking system to include a COVID-19 check box to identify any COVID-19 related compliance issues that emerged during the pandemic. FY 2020 categories are as follows:
- Conflict of Interest
- Contracts/Agreements
- Documentation
- Fraud, Waste and Abuse, and Financial Misconduct
- HIPAA Privacy, Confidentiality and Security
- Human Resources
- Quality/Patient Safety
- Regulatory/Policy
- Other (Comprised of contacts that may include Research, Theft, and miscellaneous compliance topics)

FY 2020 Contacts by Category
As with prior years, HIPAA Privacy, Confidentiality, and Security continues to comprise the largest share of contacts that come to Corporate Compliance. In FY 2020, 378 or 38%, were categorized within this category. Of the documented contacts, approximately 10% or 37 contacts were confirmed privacy breaches that required notification for 203 patients.
It should be noted that Corporate Compliance investigated and followed reporting obligations for a breach impacting more than 500 individuals that occurred at the end of FY 2019. In response to this report, the Office for Civil Rights (OCR) sent an investigation notice to CCH which requested documentation on the breach as well as CCH’s policies and procedures and mitigation efforts. The Privacy Officer complied the requested documentation and responded to OCR in March 2020. OCR accepted the documentation and closed the investigation in April 2020.

<table>
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<th>Categories</th>
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<tr>
<td>Human Resources</td>
<td>77</td>
<td>Other</td>
<td>37</td>
</tr>
</tbody>
</table>

**FY 2020 Contact Status**

Of the 983 contacts throughout FY 2020, 96% or 947 contacts were resolved at the end of the fiscal year. The remaining contacts carried into FY 2021. Of the contacts resolved, 97% were either managed internally by Corporate Compliance or Corporate Compliance partnered with another area to address the concerns raised. This metric is consistent year-over-year.

**FY 2020 Proactive vs. Reactive**

It has been a longstanding goal of Corporate Compliance to restore balance to the number of proactive versus reactive contacts that come into the department. However, due to the emergence of COVID-19, efforts toward undertaking significant proactive work were halted. Further, proactive efforts cannot be successful without appropriate staffing. Due to the staffing shortages in Compliance, limited proactive work is able to be accomplished.
Of the 983 compliance contacts managed during FY 2020, 617 contacts or 63% were reactive. Reactive contacts occur in response to an action that has already been initiated. On the proactive side, 37% or 366 contacts were classified as proactive. The proactive category is defined as questions brought to the attention of Corporate Compliance by individuals seeking guidance prior to the occurrence of an event or activity. While not statistically significant, FY 2020 showed a 3% increase from 34% in FY 2019. Compliance is encouraged by the positive trend towards individuals seeking guidance prior to embarking upon an action.

**Element 5**

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.

**Enforcing Standards**

Broadened the scope of Standards enforcement through:

- **Breach Assessments.** Reviewed investigations and provided remediation guidance to operational areas to minimize and/or eliminate breaches in the future and, utilized the CCH Sanction Policy and Personnel Rules, to provide leadership guidance for disciplinary action.

- **Breach Notification.** Investigated all instances of lost or stolen patient information, including paper and electronic. For all instances in which the data loss constitutes a breach as defined by the Breach Notification Rule, the breach notification requirements to the patient, the Secretary of HHS, and the media are completed. Corrective action plans are created and executed to improve the processes and counsel the physicians and employees involved.

- **Conflict of Interest.** Provided guidance and developed Conflict Management Plans to preserve the integrity of the decision-making process.

- **Investigations Resulting in Employee Related Corrective Actions.** HIPAA and Conflict of Interest complaints were investigated and resulted in providing leadership guidance to remediate the situations and avoid repetition of the incident.

- **Partnerships with Governmental Agencies.** Corporate Compliance has engaged both state and federal agencies (e.g. the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), Office for Civil Rights (OCR), Federal Bureau of Investigations, Department of Healthcare and Family Services (HFS), HFS
Office of the Inspector General, and the Medicaid Fraud Control Unit) on a variety of matters. Additionally, Compliance has worked with the Cook County Office of the Independent Inspector General.

### Element 6

*The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem area.*

#### Auditing and Monitoring

**HIPAA Auditing and Monitoring.** The Privacy side of the Corporate Compliance conducted ongoing HIPAA auditing and monitoring of access to the electronic health record by:

- Investigating all allegations of inappropriate access to the electronic record;
- Utilizing the auditing tool, Cerner P2Sentinelle, to run reports showing access to certain electronic health records;
- Working with operational leadership to take appropriate disciplinary action and educate staff when inappropriate access is determined; and
- Collaborating with HIS to review prior security audits and identify key areas of risk to address in FY 2020 and moving forward.

**Coding Audit.** The Corporate Compliance Program engaged an independent third party to perform an External Professional Fee Coding Probe Audit. The audit revealed opportunities within the following areas:

- Coding quality and specificity for diagnosis and procedure assignment;
- Improvement through physician documentation and coding nomenclature education; and
- Adjustments with laboratory billing to correct inaccuracies.

Upon completion of external audit, shared audit results with CCH HIM, who ensured that all claims with revenue impact were re-billed. Recognizing clinical codes have a systemic impact to the revenue cycle, as such a Corrective Action Plan was implemented. Additionally, in FY 2021, Corporate Compliance will develop a Coding Integrity Program to add additional structured oversight to monitor accuracy and facilitate improvements.

#### Risk Assessment

The Corporate Compliance Program risk assessment process is dynamic, and adjustments are made throughout the year to respond to emerging issues with the resources available. This report highlighted activities that minimized risk through the introduction and enforcement of policies and standards, auditing and monitoring, education, and issue investigations with corrective action plans as appropriate.

Through surveys of executive leadership and key thought leaders within the organization, overlaying industry risks, and through the course of activities within prior fiscal years, the following areas were identified in FY 2020 as areas of concern,
• Using, disclosing, and safeguarding PHI, in all forms, with emphasis on data security through encryption and other available technologies, was incredibly important during the COVID-19 PHE;

• Examining patient data to ensure accurate registration and deter identity theft and merged electronic health records;

• Advising Supply Chain Management during contract negotiations in the areas of compliance, privacy and security, including the review and execution of Business Associate Agreements with business partners that may have access to PHI;

• Assessing documentation supports the services performed through accurate code assignment;

• Assuring sanction screening was performed during the onboarding process for employees and vendors;

• Monitoring the 340B Drug Pricing Program through oversight and participation on the Pharmacy’s 340B Committee;

• Evaluating the current Record Retention Schedule for Cook County Health to determine next steps for updating the document to a user friendly tool; and

• Partnering with physicians to accentuate the need for them to manage their prescription activity with the Illinois Drug Prescription Monitoring Program to eliminate fraudulent controlled substance prescriptions.

Element 7

The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.

Sanction Screening Checks

• A policy and procedure paralleling the requirements set forth by the Department of Health and Human Services, Office of Inspector General, is in place to ensure the screening of all contractors and workforce members.

• The policy is placed to avoid employing, engaging, contracting or agreeing with any individual or entity that is 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.

• CCH screens all employees prior to hire and vendors prior to contracting.

• Delegated vendors attest to screening of all workforce members upon hire and routinely thereafter.

• Corporate Compliance, through an independent third party, is responsible for subsequent screenings. The third-party screens workforce members, employees of delegated vendors that work at CCH locations or have contact with a patient or CountyCare member, monthly and annually.

• Determined, through an independent third party, no excluded or sanctioned CCH workforce members or vendors were identified throughout this fiscal year.
VII. Looking Ahead to 2021

Year-Over-Year, the CCH Compliance Program continues to,

- Serve as a Corporate Compliance resource to all that require assistance throughout CCH;
- Continue to monitor regulatory changes as they relate to compliance and disseminate accordingly;
- Respond to inquiries, allegations, and complaints brought to the attention of Compliance;
- Implement solutions aimed at identifying and resolving preventable risks;
- Assess and reassess compliance and privacy policies and procedures; and
- Promote the CCH Corporate Compliance Program internally and externally.

Notable priorities for FY 2021 include:

- **CCH Compliance Program Evaluation**: Facilitating an external, independent effectiveness evaluation of the Compliance Program. Both the Department of Justice (DOJ) and HHS Office of Inspector General (OIG) call for periodic assessments of compliance program effectiveness, stressing Programs should not remain static but continue to evolve and improve over time in response to the ever changing legal and regulatory environment. Therefore, a key objective of the review will be to both verify and document strengths in the Compliance Program, but also seek opportunities where improvements and enhancements can be made.

- **Research Compliance Program**: Research is a heavily regulated environment, as such, having a Research Compliance Program in place is fundamental for ensuring compliance with the various laws and regulations from multiple agencies and enforcement bodies. The development of a Research Compliance Program can aid in identifying legal and regulatory problems, corrects deficiencies, and assist in preventing future problems.

- **Coding Integrity Program**: Accurate representation of a patient’s clinical status is translated into coded data. These clinical codes have a systemic impact to the revenue cycle, organizational decision-making, clinical protocols, research outcomes and external reporting. The implementation of a Coding Integrity Program within Compliance adds additional structured oversight to monitor accuracy, facilitate improvements and strengthen reporting.

- **Compliance Education**: Refresh, renew, and rethink all compliance training materials including new employee orientation, annual education, and ad hoc refresher training.

- **Safeguard Protected Health Information (PHI)**: Continue emphasis on the importance of safeguarding PHI as required by HIPAA while also introducing staff to heightened privacy requirements for specially protected classes of patients. This includes strengthening guidance documents, policies and procedures and updating education material.
ATTACHMENT #2
Internal Audit

Open Meeting

Overview of Internal Audit
Internal Audit Overview

Mission

Internal Audit serves as a trusted advisor to the Board of Directors, its Audit and Compliance Committee, and to the Senior Leadership team and operating management of CCHHS

Vision

Internal Audit provides independent, objective assurance and consulting services to its stakeholders in matters of risk management, controls, and governance. Internal Audit; aligns its activities with CCHHS’s mission/strategy, provides customer driven service, provides education, collaborates with stakeholders and customers, promotes the value of good controls and ethical behavior, and provides value-added services to its stakeholders.

Goals

I. Trusted Advisor

II. Promote risk management, controls, governance

III. Collaborate with stakeholders

IV. Provide education to stakeholders and customers

V. Provide stakeholders with value added services

VI. Provide exceptional customer service

Indicators

• Objective
  • Independent
  • Confidential

• Internal Audit Charter
  • Internal Audit resources support Charter
  • Professional associations
  • Risk assessments and internal audit work plans

• Stakeholder expectations
  • Communication
  • Methodology

• Best practices, roles, responsibilities
  • Internal Audit work plans
  • Methodology

• Consultative
  • Recommendations
  • Follow up

• Quality assurance
  • Metrics
INTERNAL STANDARDS FOR THE PROFESSIONAL PRACTICE OF INTERNAL AUDITING (STANDARDS)

Attribute Standards

1000 – Purpose, Authority, and Responsibility
The purpose, authority, and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Definition of Internal Auditing, the Code of Ethics, and the Standards. The chief audit executive (CAE) must periodically review the internal audit charter and present it to senior management and the board for approval.

Interpretation:
The internal audit charter is a formal document that defines the internal audit activity’s purpose, authority, and responsibility. The internal audit charter establishes the internal audit activity’s position within the organization, including the nature of the chief audit executive’s functional reporting relationship with the board; authorizes access to records, personnel, and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities. Final approval of the internal audit charter resides with the board.
Internal Audit Charter

1110 – Organizational Independence

The chief audit executive must report to a level within the organization that allows the internal audit activity to fulfill its responsibilities. The chief audit executive must confirm to the board, at least annually, the organizational independence of the internal audit activity.

Interpretation:

Organizational independence is effectively achieved when the chief audit executive reports functionally to the board. Examples of functional reporting to the board involve the board:

- Approving the internal audit charter;
- Approving the risk based internal audit plan;
- Approving the internal audit budget and resource plan;
- Receiving communications from the chief audit executive on the internal audit activity’s performance relative to its plan and other matters;
- Approving decisions regarding the appointment and removal of the chief audit executive;
- Approving the remuneration of the chief audit executive; and
- Making appropriate inquiries of management and the chief audit executive to determine whether there are inappropriate scope or resource limitations.
Internal Audit Charter

Considerations for Implementation

Based on this foundational work, the CAE (or a delegate) drafts an internal audit charter. The IIA offers a model internal audit activity charter that may be used as a guide. Although they vary by organization, charters typically include the following sections:

Introduction – to explain the overall role and professionalism of the internal audit activity, citing the relevant elements of the International Professional Practice Framework (IPPF).

Authority – to specify the internal audit activity’s full access to the records, physical property and personnel required to perform its engagements and to declare its accountability for safeguarding assets and confidentiality.

Organization and Reporting Structure – to document the CAE’s reporting structure. The CAE reports functionally to the board and administratively to a level within the organization that allows the internal audit activity to fulfill its responsibilities. This section may delve into specific functional responsibilities, such as approving the charter and audit plan, and hiring, compensating, and terminating the CAE; as well as administrative responsibilities, such as supporting information flow within the organization or approving human resource administration and budgets.

Independence and Objectivity – to describe the importance of internal audit independence and objectivity and how these will be maintained, such as prohibiting internal audit from having operational responsibility or authority over areas audited.

Responsibilities – to lay out major areas of ongoing responsibility, such as defining the scope of assessments, writing an audit plan and submitting it to the board for approval, performing assessments, communicating the results, providing a written audit report, and monitoring corrective actions taken by management.

Quality Assurance and Improvement – to describe the expectations for maintaining, evaluating, and communicating the results of a quality program that covers all aspects of the internal audit activity.

Signatures – to document the agreement between the CAE, a designated board representative, and the individual to whom the CAE reports, with the date, name, and title of signatories.
Thank you.
Mission
Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organization’s operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Internal Audit will align its activities with the mission and strategy of CCH. Internal Audit will promote good controls and serve as an educational resource to its stakeholders with respect to risk management, control and governance processes. Internal Audit will maintain a collaborative approach to its work practices and will ensure its work product provides value added outputs for its stakeholders.

Role
- Internal Audit’s role is determined by the CCH Board of Directors through its Audit and Compliance Committee.
- Internal Audit’s responsibilities are defined by the CCH Board of Directors through its Audit and Compliance Committee.

Professional Standards
- The Institute’s “International Professional Practice Framework” shall constitute the operating procedures for the department. These documents are considered an addendum to this Charter. http://www.theiia.org/guidance/standards-and-guidance/ippf/standards/
- Internal Audit will adhere to all CCH policies and procedures and all Internal Audit procedure manuals.

Authority
Internal Audit is authorized to:
- Have unrestricted access to all functions, records, property and personnel.
- Have free, open, and timely access to the Chief Executive Officer and the CCH Board of Directors through its Audit and Compliance Committee.
- Allocate department resources, set frequencies, select subjects, determine scope of work and apply the techniques required to achieve audit objectives.
- Obtain the necessary assistance of personnel in the organization when performing audits, as well as other specialized services from within or outside the organization.

Independence
- All audit activities shall remain free of influence by any element in the organization, including matters of audit scope, procedures, frequency, timing, or report. Such actions shall not permit the independence required to render objective reports.
- Internal auditors shall have no operational responsibility or authority over any activities they review.
- Internal auditors shall not develop or install systems or procedures, prepare records or engage in any other activity that they would normally audit.
• Internal Audit reports functionally to the CCH Board of Directors through its Audit and Compliance Committee and administratively to the Chief Executive Officer.
• Internal Audit periodically reports to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership as outlined in the section on Accountability.

Accountability
Internal Audit is accountable to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership to:
• Report significant issues related to the process for controlling the activities of the organization, including potential improvements to those processes, and provide information concerning such issues through resolution.
• Provide information periodically on the status and results of the annual audit plan and the sufficiency of internal audit resources.
• Coordinate with and provide oversight of other control and monitoring functions.

Audit Scope
The scope of the work of Internal Audit is to determine whether the network of risk management, control and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

• Risks are identified and managed.
• Interaction with various governance groups occurs as needed.
• Significant financial, managerial and operating information is accurate, reliable and timely.
• Employee’s actions are in compliance with policies, standards, procedures and applicable laws and regulations.
• Resources are acquired economically, used efficiently, and adequately protected.
• Programs, plans and objectives are achieved.
• Quality and continuous improvement are fostered in control processes.
• Significant legislative or regulatory issues impacting the organization are recognized and addressed properly.

Responsibility
• Develop an annual audit plan using risk-based methodology, including any risk or control concerns expressed by management, and submit the plan to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership for approval.
• Implement the audit plan and any special requests by the CCH Board of Directors, its Audit and Compliance Committee, and CCH Senior Leadership and management.
• Maintain a professional audit staff capable of meeting the requirements of this Charter.
• Establish a quality assurance program whereby the director of internal audit assures the operations of internal audit.
• Perform consulting services in addition to assurance services. Consulting services are defined as "advisory and related client services activities, the nature and scope of which are agreed with the client and which are intended to add value and improve the organization’s governance, risk management and control processes without the internal auditor assuming management responsibility.” Examples include counsel, advice, facilitation, and training.
• Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations and control processes, coincident with their development, implementation and/or expansion.
• Issue periodic reports to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership summarizing results of internal audit activities.
• Inform the CCH Board of Directors through its Audit and Compliance Committee, and CCH Senior Leadership of emerging trends and successful practices in internal auditing.
• Provide the CCH Board of Directors through its Audit and Compliance Committee, and CCH Senior Leadership a list of internal audit measurement goals and results.
• Assist in the investigation of significant suspected fraudulent activities.
• Consider the scope of work of the external auditors and regulators for the purpose of providing optimal audit coverage at a reasonable cost.

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Mike Koetting
Audit and Compliance Committee Chair

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Israel Rocha Jr.
Chief Executive Officer

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Tom Schroeder
Director of Internal Audit