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, April 19, 2024 at the hour of 9:00 A.M., at 1950 West Polk Street, Room 5301, in Chicago, Illinois.

I. Attendance/Call to Order

Chair Harrington called the meeting to order.

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

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

Absent: None (0)

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

Additional attendees and/or presenters were:

Nicole Almiro – Chief Corporate Compliance and Privacy Officer
Jeff McCutchan – General Counsel
Erik Mikaitis, MD – Interim Chief Executive Officer
Angela O'Banion – Chief Information Officer
Alisha Patel – Assistant General Counsel
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit

The next regular meeting of the Audit and Compliance Committee is scheduled for Friday, June 21, 2024 at 9:00 A.M.

II. Public Testimony

There was no public testimony submitted.

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

A. Action Items: Approval of: (Attachment #2)

- **2024 CountyCare Compliance Plan**
- **2024 CountyCare Fraud, Waste and Abuse Plan**

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

> Chair Harrington, seconded by Director Reiter, moved to approve the 2024 CountyCare Compliance Plan and 2024 CountyCare Fraud, Waste and Abuse Plan. THE MOTION CARRIED UNANIMOUSLY.

IV. Report from Director of Internal Audit (Attachment #3)

A. Action Item – Approval of proposed Internal Audit Charter (Attachment #4)

Tom Schroeder, Director of Internal Audit, provided an overview of the proposed Internal Audit Charter. The Committee reviewed the information.

Director Reiter, seconded by Director Deer, moved to approve the proposed Internal Audit Charter. THE MOTION CARRIED UNANIMOUSLY.

V. Action Items

A. Accept Minutes of the Audit and Compliance Committee Meeting, January 19, 2024

Director Reiter, seconded by Director Deer, moved to accept Item V(A) the Minutes of the Audit and Compliance Committee Meeting of January 19, 2024. THE MOTION CARRIED UNANIMOUSLY.

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

VI. Closed Meeting Items

A. Report from Director of Internal Audit
B. Report from Chief Corporate Compliance Officer
C. Discussion of Personnel Matters

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

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 Harrington and Directors Deer and Reiter (3)

Nays: None (0)

Absent: None (0)

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

Chair Harrington declared that the closed meeting was adjourned. The Committee reconvened into the open meeting.

VII. Adjourn

Before the meeting adjourned, Chair Harrington and the Committee commended Ms. Almiro and Mr. Schroeder for their hard work and dedication in each of their respective areas.

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

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

XXXXXXXXXXXXXXXXXXXXXX
Joseph M. Harrington, Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

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

ATTACHMENT #1

Corporate Compliance Report

Audit & Compliance Committee of the Board of Directors

April 19, 2024

COOK COUNTY HEALTH

Meeting Objectives

Review CountyCare Compliance & Fraud, Waste and Abuse Plan

- Request for Approval

CountyCare HEALTH PLAN

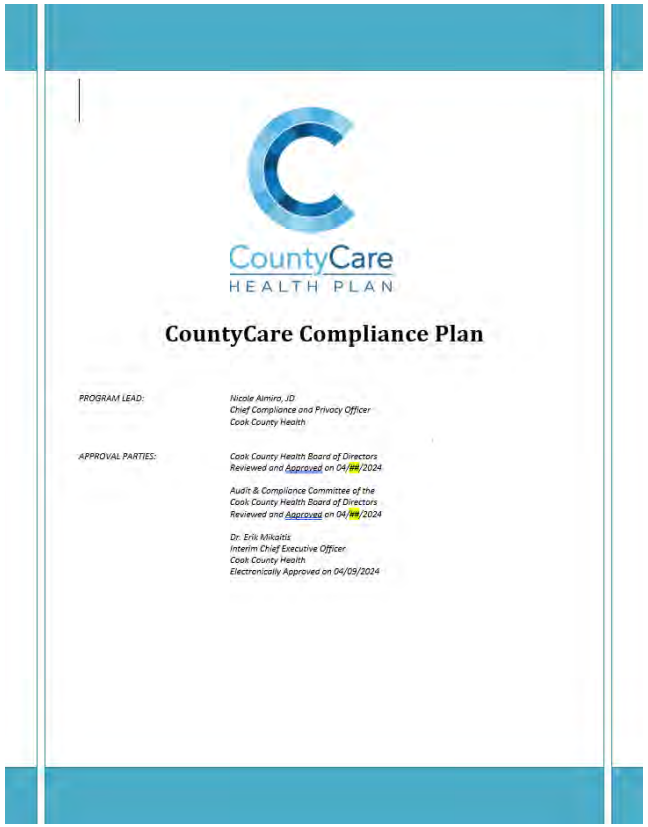
Compliance Plan

Request for Approval

COOK COUNTY HEALTH

Annual Review of the CountyCare Compliance Plan

Continues to follow the 7 elements of an effective compliance program


CountyCare
HEALTH PLAN

CountyCare Compliance Plan

PROGRAM LEAD: Nicole Aimira, JD
Chief Compliance and Privacy Officer
Cook County Health

APPROVAL PARTIES: Cook County Health Board of Directors
Reviewed and Approved on 04/##/2024

Audit & Compliance Committee of the
Cook County Health Board of Directors
Reviewed and Approved on 04/##/2024

Dr. Erik Mikaitis
Interim Chief Executive Officer
Cook County Health
Electronically Approved on 04/09/2024

1. Follows requirements found in the MCCN and amendments;
2. Holds all partners accountable for compliance;
3. Commits to maintain confidentiality and protections for whistleblowers;
4. Strengthens fraud and abuse procedures; and
    a. Integrates the FWA Plan.

Request for approval


CountyCare
HEALTH PLAN

Fraud, Waste and Abuse Plan

COOK COUNTY HEALTH

Questions?

COOK COUNTY HEALTH

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

ATTACHMENT #2

CountyCare Compliance Plan

PROGRAM LEAD:

Nicole Almiro, JD
Chief Compliance and Privacy Officer
Cook County Health

APPROVAL PARTIES:

Cook County Health Board of Directors
Reviewed and Approved on 04/##/2024

Audit & Compliance Committee of the
Cook County Health Board of Directors
Reviewed and Approved on 04/##/2024

Dr. Erik Mikaitis
Interim Chief Executive Officer
Cook County Health
Electronically Approved on 04/09/2024

APPROVED

APR 26 2024

BY BOARD OF
DIRECTORS OF THE COOK COUNTY
HEALTH AND HOSPITALS SYSTEM

Table of Contents

1.0 Introduction

CountyCare is a County Managed Care Community Network ("MCCN") plan offered by Cook County Health ("CCH") pursuant to a contract (County MCCN Contract") with the Illinois Department of Healthcare and Family Services ("HFS"). CountyCare is designed to provide coverage for any Cook County Medicaid eligible beneficiaries and transform CCH into a patient-centered continuum of care. The operation of the CountyCare MCCN is facilitated through CCH and its various subcontractors. All personnel tasked with CountyCare operational responsibilities are CCH personnel or subcontractors, agents and non-CCH providers.

As an integral part of CCH, CountyCare will uphold the mission, vision, and core goals of the system by establishing and supporting a system-wide culture of honesty and respect to guide individual's actions by developing standards, increasing awareness, and promoting honest behavior and professional responsibility through education, awareness, and shared accountability that promotes compliance with applicable laws, regulations, and system policies.

CountyCare has developed this CountyCare Compliance Plan to 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. The CountyCare Compliance Plan is structured around the seven (7) elements of an effective compliance program as required by Section 5.35 of the County MCCN Contract with HFS and as recommended in the Department of Health and Human Services Office of Inspector General ("OIG") Compliance Program Guidance publications and required by the Centers for Medicare & Medicaid Services ("CMS") Managed Care Program Integrity requirements found at 42 C.F.R. §438.608. The CountyCare Compliance Plan is managed and maintained by the CCH Office of Corporate Compliance and is submitted to the HFS Office of Inspector General ("HFS OIG") for prior approval on an annual basis.

2.0 Purpose

All personnel are expected to uphold honest and ethical behavior, comply with laws, regulations, and system policies, and to fulfill their responsibilities as important members of the CCH organization. In order to preserve this environment, all personnel, providers, and subcontractors are expected to demonstrate the highest ethical standards in performing their daily tasks. The purpose of the CountyCare Compliance Plan is to communicate the compliance expectations to all CountyCare stakeholders, including standards related to the prevention and detection of fraud, waste, abuse, and financial misconduct within health plan operations. This communication is intended to reduce the likelihood of improper conduct within the CountyCare organization and among its many stakeholders.

Further, the CountyCare Compliance Plan outlines guidelines to:

- Comply with the CMS Medicaid Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan MCCN Contract with HFS;
- Prevent, detect, and eliminate fraud, waste, abuse, mismanagement and misconduct (collectively "FWA");
- Protect health plan members, providers, CountyCare and the State from potentially fraudulent and unethical activities; and
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

3.0 Definitions and Abbreviations

Abuse means a manner of operation that results in excessive or unreasonable costs to the Federal or State health care programs, generally used in conjunction with "Fraud" and "Waste"; or the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish (42 C.F.R. § 488.301), generally used in conjugation with "Neglect."

Centers for Medicare & Medicaid Services ("CMS") means the agency within DHHS that is responsible for the administration of the Medicare program and, in partnership with the states, administers Medicaid, the State Children's Health Insurance Program and the Health Insurance Portability and Accountability Act ("HIPAA").

Confidential Information means any material, data, or information disclosed by either HFS or CountyCare to the other that, pursuant to agreement of CountyCare and HFS, or the State's grant of a proper request for confidentiality, are not generally known by or disclosed to the public or to Third Parties, including, without limitation:

1. All materials; know-how; processes; trade secrets; manuals; confidential reports; services rendered by the State; financial, technical, and operational information; and other matters relating to the operation of CountyCare's business;
2. All information and materials relating to Third-Party Contractors of the State that have provided any part of the State's information or communications infrastructure to the State;
3. Software; and

Any other information that the Parties agree shall be kept confidential.

DHHS means the United States Department of Health and Human Services.

DHS means the Illinois Department of Human Services, and any successor agency.

DHS-OIG means the Department of Human Services Office of Inspector General that is the entity responsible for investigating allegations of Abuse and Neglect of people who receive Mental Health or Developmental Disabilities services in Illinois and for seeking ways to prevent such Abuse and Neglect.

Fraud means knowing and willful deception, or a reckless disregard of the facts, with the intent to receive an unauthorized benefit. "Fraud" is generally used in conjunction with "Waste" and "Abuse."

HFS means the Illinois Department of Healthcare and Family Services and any successor agency (may also be referred to as "Agency" or "the Department").

Health Plan means a delivery system of coordinated services that a Potential Enrollee or Enrollee may select or be assigned to for health care, as implemented by the Department. A Health Plan includes delivery systems such as a HMO, MCCN, Care Coordination Entity and Accountable Care Entity**.**

Managed Care Community Network ("MCCN") means an entity other than an HMO that is owned, operated, or governed by Providers of healthcare services under contract with the Department exclusively to Persons participating in programs administered by the Department, as defined by 89 Ill. Admin. Code Part 143.100

Managed Care Organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract with HFS to provide covered services under the HFS Medical Program, as provided in 42 CFR §438.2. MCOs include Health Management Organizations ("HMOs") and MCCNs.

Mandated Reporting means the required, immediate reporting of suspected maltreatment when a mandated reporter has reasonable cause to believe that an individual known to the mandated reporter in a professional or official capacity may be subject to Abuse or Neglect.

Neglect means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.

Office of Inspector General ("HFS OIG") means the Office of Inspector General for the Department of Healthcare and Family Services, as set forth in 305 ILCS 5/12-13.1. HFS OIG has the primary responsibility for program integrity over the Illinois Medical Assistance Program to prevent, detect, and eliminate Fraud, Waste, Abuse, mismanagement, and misconduct. HFS OIG is the liaison with federal and state law enforcement, including but not limited to the Medicaid Fraud Control Unit ("MFCU").

Personnel includes CCH employees, which includes CountyCare staff, medical staff, house staff, research staff, Board members, Board appointed committee members, volunteers, students, consultants, agency personnel, and vendors.

Plan Member means a Participant who is enrolled in the CountyCare Health Plan.

Provider means a Person enrolled with the Department to provide Covered Services to CountyCare plan members.

State means the State of Illinois, as represented through any State agency, department, board, or commission.

Subcontractor means an entity, other than a Network Provider, with which CountyCare has entered into a written agreement for the purpose of delegating responsibilities applicable to CountyCare under the County MCCN Contract with HFS, as provided in 42 CFR §438.2. When not used as a defined term, "subcontractor" means any subcontractor of CountyCare, including Network Providers and Subcontractors.

Waste means the unintentional misuse of resources, resulting in unnecessary cost to CountyCare.

4.0 CountyCare Compliance Plan Overview

The CCH Chief Compliance and Privacy Officer, in partnership with the Compliance Officer, CountyCare, and in consultation with CountyCare Senior Leadership, the CountyCare Regulatory Compliance Committee, and the CCH Board of Directors, through the Audit & Compliance Committee of the Board of Directors, are responsible for coordinating the implementation of the CountyCare Compliance Plan. The CountyCare Compliance Plan is subject to ongoing review and revision as deemed necessary to ensure compliance. It is designed to accommodate future changes in regulations and laws and may be updated to address issues not currently covered or issues related to new service offerings or regulatory requirements.

5.0 CountyCare Compliance Plan Elements

CountyCare's Compliance Plan incorporates the seven elements of an effective compliance program as mandated by the County MCCN Contract with HFS and the CMS Medicaid Managed Care Program Integrity

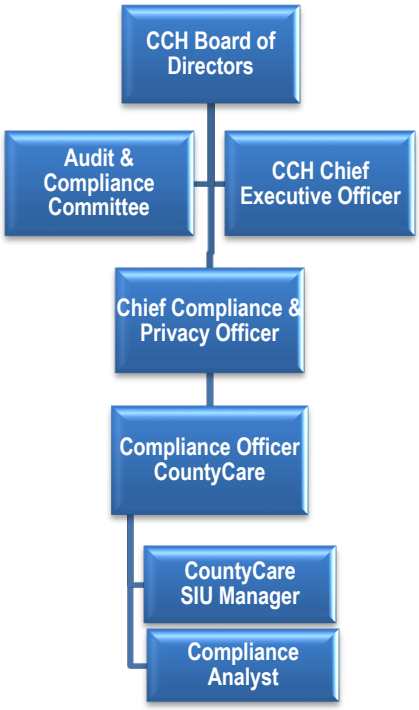
requirements. It includes the following specific controls to ensure CountyCare meets all federal, state, and contractual requirements. Elements of CountyCare's Compliance Plan include:

1. **Written Policies, Procedures and Standards of Conduct.** The CCH Code of Ethics applies to all CountyCare Personnel, Providers, 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, governing program integrity and the detection and prevention of fraud, waste, abuse, mismanagement, and misconduct including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

   CountyCare Personnel have access to compliance policies and procedures via the CCH intranet portal. CountyCare compliance policies and procedures address various components of program integrity including but not limited to the following subject areas:
   - Code of Ethics
   - Corporate Compliance Mission and Vision Statement
   - Compliance Program operational documentation and processes, including:
     - Position Descriptions
     - Board, Committee and Subcommittee Charter Statements
     - Mandatory Training Requirements (for new workforce members and annual training)
     - Compliance Hotline and Methods for Communication
     - Excluded Providers Sanction Screening
     - Compliance Auditing and Monitoring
     - Compliance Investigations
     - False Claims Act and Whistleblower Protections
   - Program Integrity/FWA related policies, including:
     - FWA Reporting and Non-Retaliation
     - Overpayment and Recovery of Claims
     - Provider Preventable Conditions
     - Recipient Restriction Program
     - Recipient Verification of Services Rendered by Provider
     - Fulfilling Data Requests and Acting Upon Provider Alerts Policy
     - Conflict of Interest
   - Confidentiality, Privacy and Security (HIPAA) Policies

   Delegated vendors (also referred to as Subcontractors) are contractually required upon initiation of contract and annually, to assure consistency and adherence to the CCH Code of Ethics and CountyCare's Corporate Compliance Program policies. Similarly, Network Providers are contractually required to abide by and cooperate with CountyCare's Program Integrity/FWA program, which is consistent with CountyCare's policy, procedures, State and federal law. CountyCare communicates FWA program requirements and compliance updates to its Network Providers via the Provider contracting process, the Provider Manual and through the network services team.

2. **Compliance Officer and Compliance Oversight Committee.** The CCH Chief Compliance and Privacy Officer and the Compliance Officer, CountyCare, and their designees, oversee and are ultimately responsible for developing, assessing, and administering the CountyCare Compliance Plan. The CCH Chief Compliance and Privacy Officer reports and is accountable to the CCH Board of Directors, through the Audit & Compliance Committee of the Board, and the CCH Chief Executive Officer ("CEO").



The CCH Chief Compliance and Privacy Officer, the Compliance Officer, CountyCare and their designees, are responsible for oversight of:

- The CountyCare Compliance Plan;
- Development and implementation of policies, procedures and practices designed to ensure compliance with the County MCCN Contract with HFS, including requirements related to program integrity;
- Operational compliance with the complaint, grievance, appeals, and fair hearing process;
- Accurate fraud, waste, abuse, mismanagement, and misconduct reporting in accordance with regulatory requirements;
- Serving as the single liaison to HFS regarding the reporting of suspected fraud, waste, abuse, mismanagement, or misconduct.

The CountyCare Regulatory Compliance Committee, consisting of members of CountyCare Senior Leadership is tasked with general oversight of the CountyCare Compliance Plan operations, compliance with the County MCCN Contract, and overall support of the CountyCare culture of compliance. Specifically, the CountyCare Regulatory Compliance Committee is responsible for:

- Overseeing the implementation of CountyCare Compliance Plan;
- Providing oversight and guidance regarding CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary;
- Updating members on regulatory, contractual and statutory matters affecting Compliance activities of CountyCare;
- Meeting regularly, no less than quarterly, and as needed;
- Appointing a liaison to HFS to report potential fraud, abuse, or financial misconduct;

- Ensuring compliance with monthly and quarterly CountyCare Health Plan FWA reporting requirements; and
- Reporting to the CCH Board of Directors, through the Audit & Compliance Committee of the Board, and the CEO.

The CCH Audit & Compliance Committee of the Board is tasked with general support and oversight of the CountyCare Compliance Plan operations and compliance with the County MCCN Contract. The CCH Chief Compliance and Privacy Officer and Compliance Officer, CountyCare provide reports to the Audit & Compliance Committee of the Board on a regular basis on the operations and effectiveness of the Compliance Program. Members of senior leadership of CountyCare attend meetings of the Audit & Compliance Committee of the Board on an as needed basis.

3. **Effective Training and Education.** Providing initial and continuing education for all Personnel, including members of the Board of Directors, Providers and Subcontractors is a significant element of CountyCare's Compliance Plan. Applicable Personnel receive training at hire/contract initiation and annually thereafter on their responsibilities under the CountyCare Compliance Plan, Code of Ethics, the CountyCare Cultural Competency Plan, HIPAA Privacy and Security, and how to prevent, detect identify, and report FWA. CountyCare will also provide task oriented and job-specific compliance training to Personnel, Providers and Subcontractors on an as needed basis.

   Policies and procedures are in place to ensure that all Personnel, Providers and Subcontractors complete training as mandated by regulatory and contractual obligations. Training completion is documented and maintained, as are the training materials used.

   Subcontractors are contractually required upon initiation of contract and annually, to assure consistency and adherence to the CCH Compliance related training requirements.

4. **Effective Lines of Communication.** CountyCare has implemented clear policies and procedures for reporting concerns related to compliance, program integrity, and FWA. All Personnel, Providers and Subcontractors have a duty to report misconduct including actual or potential violations of law, regulation, policy, procedure or the CCH Code of Ethics to the Chief Compliance and Privacy Officer. Failure to report a violation may result in appropriate disciplinary action. Personnel, Providers and Subcontractors are protected from retaliation and harassment as a result of having reported a good faith compliance or integrity concern.

   CountyCare maintains procedures for Personnel, Providers and Subcontractors that include multiple mechanisms for reporting instances of suspected fraud, waste, abuse, mismanagement and misconduct. Additionally, CCH makes regular communications to its Personnel and Subcontractors to reflect important compliance information and updates.

   Communication mechanisms utilized by CountyCare include:
   - CCH Corporate Compliance Hot Line (operating 24 hours a day/7 days a week)
   - CCH Corporate Compliance online reporting portal: www.cchhs.ethicspoint.com
   - CountyCare Member Services Call Center
   - CountyCare Fraud, Waste and Abuse Hotline
   - CountyCare Compliance Plan communications, including emails, texts, flyers, posters, newsletters, and emails to CountyCare employees, contractors and members regarding compliance efforts and initiatives.

CountyCare has also implemented effective lines of communication between the Chief Compliance and Privacy Officer, the Compliance Officer, CountyCare, and Personnel, Subcontractors and the HFS OIG. CountyCare also maintains procedures for reporting instances of suspected FWA to HFS OIG.

5. **Well-Publicized Disciplinary Standards.** All Personnel, Providers and Subcontractors are informed that violations of the CountyCare Compliance Plan, Code of Ethics or program integrity-related policies and procedures will result in appropriate disciplinary action or sanctions. For CountyCare Personnel, this could mean up to and including termination of employment. Contracts with Providers and Subcontractors contain provisions regarding the organization's responsibility for adhering to CountyCare contractual requirements and applicable state and federal regulations. Non-compliance may result in termination of the contractual relationship with CountyCare and CCH, where applicable.

6. **Monitoring and Auditing.** CountyCare has implemented a monitoring and auditing program which includes written policies and procedures for routine internal monitoring as well as oversight auditing activities by the CCH Office of Corporate Compliance. The monitoring and auditing program tests and confirms compliance with CMS and HFS Medicaid managed care requirements, regulatory guidance, contractual agreements, program integrity compliance risks and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential FWA. Additionally, regular audits of Subcontractors and Providers are conducted to ensure compliance with contractual and regulatory requirements and program integrity compliance risks.

   The CCH Office of Corporate Compliance will conduct an investigation of any potential compliance problems identified in the course of self-evaluation and audits and ensure that identified compliance problems are mitigated through the use of corrective action plans. Results of monitoring and auditing activities, and subsequent corrective action plans, are reported to the CountyCare Regulatory Compliance Committee, the CCH Compliance Executive Committee, and the CCH Board of Directors, through the Audit and Compliance Committee of the Board.

7. **Prompt Response to Detected Offenses.** CountyCare has established and implemented communication methods that are available twenty-four hours a day, seven days a week to enable anyone to report program non-compliance, program integrity issues and potential FWA without fear of retaliation. Consistent with HFS contractual requirements for responding to reports of potential FWA, CountyCare has established and implemented a process that includes routine monitoring of communication mechanisms, cooperating with OIG investigations, developing and implementing appropriate corrective or disciplinary actions, and reporting instances of criminal conduct to HFS OIG within three (3) days after receiving such report.

6.0 Reporting Compliance Concerns

CountyCare supports a safe, non-threatening environment where individuals may ask questions about integrity and compliance, fraud, waste, abuse, mismanagement and misconduct matters and report their concerns. As part of the CountyCare commitment to mission and core values, anyone who has a concern has an opportunity to report those concerns confidentially and without fear of retaliation. Concerns may be submitted in a number of different ways which include:

- CountyCare Member Services Call Center: **1-312-864-8200**
- CountyCare Fraud, Waste and Abuse Hotline: **1-844-509-4669**

- CCH Corporate Compliance Hotline: **1-866-489-4949**
- CCH Corporate Compliance online reporting portal: www.cchhs.ethicspoint.com

CountyCare encourages Personnel to first speak with their manager or supervisor about any concerns. If they are uncomfortable or unsure about how to do this, CCH Office of Corporate Compliance staff members are available to help.

Those who report compliance concerns in good faith are protected from retaliation and harassment. Concerns about possible retaliation or harassment stemming from a compliance report may be reported to the Chief Compliance and Privacy Officer. The individuals that receive these reports will take the issue seriously and will immediately begin working with the Chief Compliance & Privacy Officer or designee to conduct an investigation.

7.0 Fraud, Waste and Abuse Procedures

CountyCare is dedicated to preventing, detecting, identifying, and reporting FWA, as required by federal and state statutory, regulatory and contractual obligations. Additionally, our contracted partners (benefit administrators, third party administrators, etc.) are similarly committed to attaining and maintaining compliance with Federal, State and Local laws, regulations and other guidance that address FWA detection and prevention related to Medicaid plan operations. Each benefit administrator is contractually obligated to establish a FWA program to prevent, detect and correct FWA as it relates to the administration of its corporate business and contracts. As such, there are multiple policies, processes and procedures in place to prevent, detect, investigate and report, as necessary, suspected instances of FWA involved in or that impact CountyCare operations.

CountyCare, in coordination with its benefits administrators, has developed and implemented the following FWA monitoring and reporting procedures. A separate Fraud Waste and Abuse Plan is appended to this document that outlines processes in more detail.

FWA Monitoring Procedures

- All CountyCare Subcontractors that are delegated responsibility for coverage of services or payment of claims for CountyCare are required to implement and maintain a compliance program.
- All CountyCare Network Providers are required to comply with County MCCN Contract with HFS and in particular, the Program Integrity requirements outlined therein.
- CountyCare Compliance partners with several delegated vendors, through their areas dedicated to FWA, commonly known as Special Investigation Units (“SIU”). SIU operations are delegated to the following four vendors: third party administrator, dental/vision benefit administrator, the pharmacy benefit manager and non-emergency transportation broker. The CountyCare Compliance team provides direct oversight of SIU activity.
- CountyCare SIU operations include the use of surveillance and utilization controls to identify, audit/investigate, remediate and report instances of FWA, as required by the CountyCare MCCN agreement with HFS.
- CountyCare SIU operations include FWA Investigators at a minimum ratio of one (1) Investigator to every one hundred thousand (100,000) enrollees.

- CountyCare Compliance oversees comprehensive Payment Integrity efforts dedicated to detecting, preventing and recovering potential FWA related payments, including claims edits and prepayment and post-processing reviews of claims that are focused on both in-network or out-of-network providers. The *CountyCare Fraud, Waste and Abuse: Adjudication of Incorrect Claims Payments* policy and procedure addresses how overpayments are identified and recovered.
- Workgroup meetings are convened with CountyCare SIU investigators on a regular basis.
- CountyCare reviews instances of billing anomalies and allegations related to risk of harm concerns for all members related to our Network Providers. CountyCare Compliance takes steps to triage and substantiate information related to FWA and provides timely updates to the HFS OIG and MFCU (where applicable) when concerns or allegations are substantiated.
- Member Service Verification Letters are sent to members to identify phantom providers or services that billed but were not performed.
- All Personnel, Subcontractors and Network Providers are required to complete annual training that explains the procedures for reporting potential issues and provides background information and examples of possible FWA.
- Sanction and Exclusion Screening is performed for all CountyCare Personnel, Network Providers and Subcontractors upon hire and monthly. CountyCare has procedures in place to terminate a Subcontractor when notified by HFS OIG pursuant requirements within the County MCCN Contract with HFS.
- Delegated vendor oversight and monitoring activities are conducted for Subcontractors/vendors and other delegated entities to ensure that any potential issues detected and reported by Subcontractors and vendors are appropriately identified, investigated and remediated, using corrective action plans when necessary.
- Quarterly CountyCare Regulatory Compliance Committee meetings are held to discuss new and outstanding Compliance issues, including FWA updates, and to provide oversight and guidance of CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary.

<u>FWA Reporting Procedures</u>

- CountyCare Network Providers are required to report to CountyCare when they have received an overpayment from CountyCare. The provider is required to return the identified overpayment to CountyCare within sixty (60) days of identifying the overpayment and must notify CountyCare in writing the specific reason for the overpayment and how the overpayment was identified by the provider.
- All CountyCare Personnel, Network Providers, and Subcontractors are contractually required to report any instances of suspected or actual fraud, waste, abuse, mismanagement, or misconduct.
- CountyCare Compliance policies and procedures require prompt submission of data / reports regarding potential FWA to HFS OIG using the mode of communication and/or reporting mechanisms requested by HFS OIG, including when tips are received, when overpayments are identified and when cases are closed.
- Procedures are in place for timely submission of reports regarding any suspected criminal fraud, waste, abuse, mismanagement or misconduct by CountyCare members, Providers, Personnel or Subcontractors to the HFS OIG within three (3) days after receiving such report.
- On an ad-hoc basis, CountyCare Compliance will also submit to HFS OIG:
    - Reports regarding any information that may affect a member's eligibility to participate in the Medical Assistance program, including changes in a member's address or death of a

member. Reports are provided to HFS OIG within ten (10) business days of receiving the information.

- Reports regarding any information about a change in a Network Provider's circumstances that may affect the Provider's eligibility to participate in the Medical Assistance Program, including termination of the Contractor's Provider agreement. Reports are provided to the HFS OIG within ten (10) business days of receiving the information.

8.0 Procedures for Confidential Information

CountyCare is dedicated to providing safeguards and protections for all confidential information and data, including protected health information, received and used in its health plan operations, as is required by federal and state statutory, regulatory and contractual obligations, including relevant provisions within the County MCCN Contract.

CountyCare Personnel and Subcontractors may access Confidential Information (as defined in the County MCCN Contract with HFS) or data owned or maintained by HFS in the course of carrying out its health plan responsibilities under its County MCCN Contract with HFS. CountyCare Personnel, and Subcontractors will presume that all information received from the State or HFS, or to which it gains access pursuant to the County MCCN Contract, is considered confidential.

Information maintained by CountyCare, with the exception of information regarding rates paid by CountyCare to its Providers and Subcontractors, shall be considered public unless it is clearly marked as confidential and exempt from disclosure under the Illinois Freedom of Information Act.

Confidential data collected, maintained, or used in the course of performance of the County MCCN Contract shall only be disseminated by CountyCare Personnel, and Subcontractors when authorized by law and with the written consent of the State/HFS, either during the term of the County MCCN Contract or thereafter, or as otherwise set forth in the County MCCN Contract.

CountyCare Personnel, and Subcontractors must return any and all data collected, maintained, created, or used in the course of the performance of the duties of the County MCCN Contract, in whatever form they are maintained, promptly at the end of the term of the County MCCN Contract, or earlier at the request of the State/HFS, or notify the State/HFS in writing of the data's destruction.

The requirements outlined above do not apply to confidential data or information that:

- Are lawfully in the CountyCare's possession prior to its acquisition from HFS/the State;
- Are received in good faith from a third party not subject to any confidentiality obligation to the State/HFS;
- Are now, or become, publicly known through no breach of confidentiality obligation by CountyCare; or
- Are independently developed by CountyCare without the use or benefit of the State/HFS' Confidential Information.

9.0 Cooperation with External Regulators and Enforcement Agencies

CountyCare Personnel, Network Providers, Subcontractors and Delegated Vendors shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative,

civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CountyCare's Personnel and Subcontractors/Delegated Vendors, including but not limited to those with expertise in the administration of the Medical Assistance Program, in medical or pharmaceutical questions, or in any matter related to an investigation.

CountyCare Personnel, Network Providers, Subcontractors and Delegated Vendors shall cooperate with all HFS OIG investigations, including but not limited to providing administrative, financial, and medical records related to the delivery of services and access to the place of business during normal business hours, except under special circumstances when after-hour admission shall be allowed. CountyCare Personnel, Network Providers, Subcontractors and Delegated Vendors shall also provide data to the HFS OIG when requested to support verification activities, substantiate data validation reviews, and to reconcile any differences or anomalies identified by the HFS OIG.

Addendum: CountyCare Fraud Waste and Abuse Plan

The document that follows supplements section 7.0 FWA Procedures and provides additional detail regarding the CountyCare FWA Plan.

Revision History

Initial	*Approved by CEO: 01/30/2015*	*Approved by Audit & Compliance Committee:*	*02/19/2015*
Revision 1	*Approved by CEO: 03/20/2018*	*Approved by CCH Board of Directors:*	*03/27/2018*
Revision 2	*Approved by CEO: 04/29/2020*	*Approved by Audit & Compliance Committee:* *Approved by CCH Board of Directors:*	*06/19/2020* *06/26/2020*
Revision 3	*Approved by CEO: 05/19/2021*	*Approved by Audit & Compliance Committee:* *Approved by CCH Board of Directors*	*05/21/2021* *05/28/2021*
Revision 4	*Approved by CEO: 04/09/2024*	*Approved by Audit & Compliance Committee:* *Approved by CCH Board of Directors*	*04/##/2024* *04/##/2024*

CountyCare
Fraud Waste and Abuse Plan

PROGRAM LEAD:

Nicole Almiro, JD
Chief Compliance and Privacy Officer
Cook County Health

APPROVED

APR 26 2024

BY BOARD OF
DIRECTORS OF THE COOK COUNTY
HEALTH AND HOSPITALS SYSTEM

Contents

Fraud, Waste and Abuse Plan ("FWA Plan") Overview

The prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct (collectively, "FWA") is a central component of the CountyCare Compliance Program. CountyCare, in partnership with each vendor partner and benefit administrator for the health plan, is committed to maintaining compliance with Federal, State and Local laws, regulations and guidance that FWA prevention, detection, and reporting.

Each benefit administrator that contracts with CountyCare has established a Fraud, Waste and Abuse program which is designed to prevent, detect and correct FWA as it relates to the administration of its corporate business and contracts. All CountyCare Personnel, Network Providers and Subcontractors/Vendors have the responsibility to identify, investigate and report potential FWA activities to CountyCare Compliance.

CountyCare Directors, Personnel, Subcontractors/Vendors, Network Providers, and Members are expressly prohibited from:

- Presenting a claim for payment under the Medicaid programs knowing that such claim is false or fraudulent;
- Presenting a claim for payment under the Medicaid programs knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for such benefit;
- Making or using a false record or statement to obtain payment from a Medicaid program while knowing that such record or statement is false;
- Making or using a record or statement to conceal, avoid or decrease an obligation to make a payment to a Medicaid program, knowing that such record or statement is false;
- Knowingly making a claim under the Medicaid program for a service or product that was not provided;
- Not repaying (within sixty (60) days of confirmation) a false or fraudulent claim to the government; and
- Retaining funds improperly or erroneously paid by a federal health care program.

CountyCare Compliance, through its delegated Special Investigation Unit ("SIU") operations, may conduct investigations of suspected FWA. If the investigation discloses potential criminal acts, CountyCare Compliance shall immediately notify the Illinois Department of Healthcare and Family Services Office of the Inspector General ("HFS OIG"). Additionally, CountyCare Compliance provides real time updates to HFS OIG on all investigations involving potential FWA as required by contract and as outlined in HFS OIG guidance.

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

FWA Plan Elements

The FWA Plan is designed to:

- Demonstrate CountyCare's commitment to prevent, detect and correct incidents related to potential FWA;
- Outline FWA Program staffing and resources, including SIU operations by delegated vendors and oversight by CountyCare Compliance;

- Provide guidance, education, training related to FWA processes, including mechanisms to report FWA;
- Summarize processes used to identify patterns or instances of suspicious provider or member activity related to potential FWA;
- Describe methods to perform a review, audit or investigation of any provider or member who is suspected of participating in FWA activities;
- Implement appropriate corrective action based on FWA investigations and reports, including recovery, prosecution and/or referral to enforcement agencies, when applicable;
- Outline how reports of provider or member misconduct may be received from other entities and external sources; and
- Provide information regarding how CountyCare Compliance reports potential incidents of FWA to applicable state and/or federal agencies (i.e., HFS OIG).
- Describe processes followed to identify, investigate/audit, prevent, refer and report suspected or potential FWA, in compliance with federal requirements found at 42 CFR 455.13, 42 CFR 455.14 and 42 CFR 455.21.

CountyCare Compliance reviews and updates to the FWA Plan at least annually, and as needed in order to incorporate changes to previously enacted law(s), new law(s), and relevant changes in the healthcare industry. Revisions to the FWA Plan are presented to the CCH Chief Executive Officer and the Audit and Compliance Committee of the Board for review and approval.

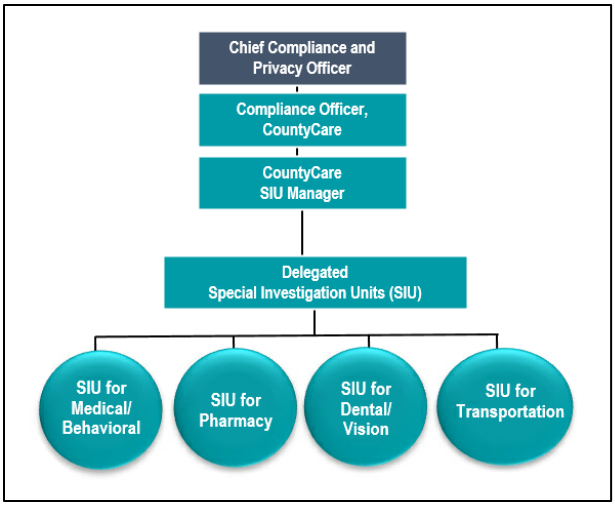
FWA Program Staffing and Resources

The FWA Plan is implemented throughout internal CountyCare operations and includes FWA responsibilities that are delegated to CountyCare benefit administrators. The Compliance Officer, CountyCare is responsible for the FWA Program and serves as the liaison to the HFS OIG.

Each benefit administrator that contracts with CountyCare has established a Fraud, Waste and Abuse program which is designed to prevent, detect and correct FWA as it relates to the administration of its corporate business and contracts. As part of their FWA program, each benefit administrator staffs a department that is dedicated to FWA operations, commonly known as an SIU.

CountyCare SIU operations include FWA investigators at a minimum ratio of one (1) Investigator to every one hundred thousand (100,000) enrollees. The CountyCare Compliance team provides direct oversight of program integrity activity, with additional reporting and oversight by the Chief Compliance and Privacy Officer. Workgroup meetings are convened with CountyCare SIU investigators on a regular basis.

The four SIUs operating on behalf of CountyCare are pictured below.



The Compliance Officer, CountyCare, in collaboration with the CountyCare SIU Manager, are responsible for timely reporting any suspected FWA in the HFS Medical Program by Enrollees, Providers, CountyCare Personnel, or Department employees to HFS OIG.

Written Policies, Procedures and Guidance

The FWA Plan includes written policies and procedures that represent commitment to honest, ethical, and responsible business conduct in compliance with Federal and State laws and regulations and professional standards. Additionally, both the CCH Code of Ethics and the CountyCare Compliance Plan outline expectations around the prevention, detection, mitigation and disclosure of FWA.

Cook County Health and CountyCare also have policies and procedures are written to provide detailed and specific information regarding the elements of the FWA Plan. FWA specific policies and procedures include but are not limited to:

- Compliance Investigations
- Fraud, Waste and Abuse Reporting and Non-Retaliation
- Auditing and Monitoring
- Overpayment and Recovery of Claims
- Adjudication of Incorrect Claims Payments
- Recipient Restriction
- Recipient Verification of Services Rendered by Provider
- Fulfilling Data Requests and Acting Upon Provider Alerts

FWA policies and procedures that support the FWA Plan are maintained electronically on a Cook County Health shared drive, in addition to the intranet.

All CountyCare Network Providers are required to comply with the Program Integrity requirements outlined the County MCCN Contract with HFS.

Each benefit administrator also enforces their FWA Program through the following activities, which are reported to CountyCare Compliance on an ongoing basis:

- Establishment of standards, policies, and procedures to address FWA;

- Establishment and implementation of an effective FWA program, including data analytics, for routine auditing and monitoring of FWA;
- Assignment of oversight responsibility for the FWA Plan;
- Effective education and training;
- Monitoring of contractual activities related to FWA;
- Development of lines of communication for reporting violations and clarifying policy regarding FWA; and
- Publicizing disciplinary standards.

FWA related updates to CountyCare policies and procedures maintained by benefit administrators are approved by CountyCare Compliance prior to implementation and dissemination. Additionally, benefit administrators are audited regularly to ensure compliance with delegated responsibilities related to FWA.

FWA Training and Education

All Personnel, Subcontractors and Network Providers are required to complete annual training that explains the procedures for reporting potential issues and provides background information and examples of possible FWA. CountyCare Personnel and Subcontractors receive training on FWA upon hire or contract and annually. CountyCare Network Providers also receive FWA training upon contracting and on an annual basis.

Benefit administrators are contractually obligated to complete FWA training upon contracting and annually. Benefit administrators are audited on an annual basis to ensure that FWA training is completed per their contractual requirements.

Lines of Communication

CountyCare Compliance works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of conducting all business activities in compliance with all laws and regulatory requirements and professional standards and reinforcing the expectation of ethical, honest, transparent, effective, and responsible behavior of all personnel.

All directors, contractors and subcontractors have an affirmative obligation to immediately report suspected violations of law, the Code of Ethics, policies and procedures, or other forms of FWA to appropriate personnel, including a supervisor or manager, the CountyCare Compliance Officer, the CCH Compliance Officer or to the CCH CEO.

CountyCare Compliance has systems in place to receive, record, and respond to FWA inquiries or reports of potential FWA.

Non-Retaliation

Personnel and Subcontractors/Vendors are prohibited from taking any retaliatory action against any person who provides a good faith report of unlawful activity or other form of fraud, waste, abuse, mismanagement, and misconduct or who participates in any internal or external investigations of such reports. Retaliation is also prohibited against any person who files and/or participates in a whistleblower suit brought under the federal or any state False Claims Act.

FWA Referrals

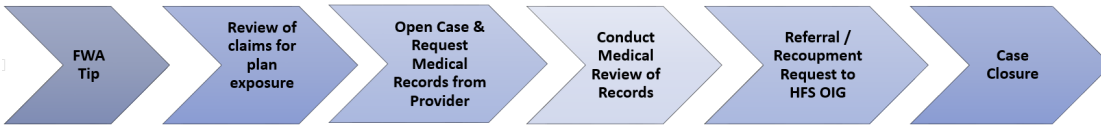
CountyCare Compliance, in partnership with its delegated SIUs, has responsibility to receive, act upon, and report FWA referrals from various sources, including but not limited to the following:

- **Hotline:** A toll-free hotline number has been established to report potential FWA activities. The FWA hotline is operated by an independent third party and all referrals are sent directly to the CountyCare Compliance and other members of the delegated SIU, as applicable. All hotline referrals receive a case number within one (1) business day.
- **Internal Referrals:** All CountyCare Personnel, Network Providers, and Subcontractors are required to report any instances of suspected or actual FWA and may do so directly to CountyCare Compliance via email, phone or in conversation.
- **Claim Edits:** CountyCare utilizes a claims editing system to reduce reimbursement errors and improve payment integrity. The claims editing system methodically checks CountyCare claims for errors, omissions, and questionable coding relationships and tests the data against government and industry rules, regulations, and policies governing healthcare claims. Referrals for further review may be identified by monitoring claim edits.
- **Data Mining by SIU for trends**: Data analytics is critically important to identify potential FWA. Using tools available, the dedicated benefit administrator team detects and deploys the most effective means to avoid and mitigate FWA for the Illinois Medicaid program. The tool refines and customizes the data analytics approach based on Illinois Medicaid policy to maximize identification and detection of FWA. Monitoring and acting upon national trends with data mining helps to identify similar trends in Illinois. This proactive approach allows for prevention of potential FWA for the Medicaid program.
- **Member Service Verification Letters:** Letters are sent to members to identify phantom providers or services that billed but were not performed. Members may report not receiving services upon receipt of verification letters.
- **Provider Referrals**: CountyCare Network Providers are required to report to CountyCare when they have received an overpayment from CountyCare. The provider is required to return the identified overpayment to CountyCare within sixty (60) days of identifying the overpayment and must notify CountyCare in writing the specific reason for the overpayment and how the overpayment was identified by the provider.
- **State/Federal Notifications**: Notifications may be received during periodic communications and meetings with the State. During meetings, other health plans and state/federal employees may provide information regarding a provider which will result in a preliminary review. This may include, but will not be limited to, Insurance Divisions, Board of Physicians Quality Assurance, Attorney General's Office, US Postal Inspector, etc.
- **Exclusion/Sanction Investigations**: CountyCare and its vendor partners will screen all current and prospective employees, contractors, and sub-contractors, prior to engaging their services and monthly thereafter by: (i) requiring them to initially disclose whether they are Excluded Persons; and (ii) reviewing the following databases;
    - System for Award Management (SAM) maintained by the United States General Services Administration (GSA);
    - The DHHS/OIG List of Excluded Individuals/Entities at https://exclusions.oig.hhs.gov/;
    - The Federal CMS Data Exchange System (DEX);
    - The Illinois Department of Healthcare and Family Services OIG databases;
    - Others as required by contract with individual health plans.

FWA Audits and Investigations

CountyCare Special Investigation Units operations include the use of surveillance and utilization controls to identify, investigate, remediate and report instances of FWA, as required by the CountyCare MCCN agreement with HFS. Regular investigations of provider and member activity are performed to ensure potential FWA activity is recognized and to proactively identify areas which may be susceptible to potential FWA.

A sample FWA investigation flow is as follows:



Investigators, certified professional coders and clinical staff assist with the review of CountyCare records when audits or further review needs to be conducted for investigations resulting from referrals or from data mining activities. The medical record review and audit process consists of reviewing medical records against claims submitted and payments made to ensure payment accuracy for services performed. The provider has the opportunity to review and provide additional information or appeal before any action for recovery is taken by CountyCare.

In addition, the organization is committed to the identification of aberrant provider billing practices through data mining and algorithmic analysis. Provider behavior is monitored and, if the coding patterns are unchanged or inadequate responses are received, a provider may be subject to pre-and/or post payment claims review. Collaboration occurs between each benefit administrator and CountyCare Compliance. Referrals are made to the CountyCare Compliance and benefit administrator's team based upon the provider's response to the claims review findings.

CountyCare Compliance, through its delegated SIU operations, may conduct investigations of suspected FWA of its Personnel, Network Providers, Subcontractors/Vendors, or Members only to the extent necessary to determine whether reporting to HFS OIG is required, or when CountyCare Compliance has received the express concurrence of the OIG. If the investigation discloses potential criminal acts, the Compliance Officer, CountyCare shall immediately notify HFS OIG.

Reporting to HFS OIG

CountyCare Compliance policies and procedures affirmatively require prompt submission of data / reports regarding potential FWA to HFS OIG using the mode of communication and/or reporting mechanisms requested by HFS OIG, including real time updates of when tips are received, when overpayments are identified and when cases are closed. Reports are also provided to HFS OIG on a monthly basis regarding member Lock In Program activity.

Procedures are in place for timely submission of reports regarding any suspected criminal fraud, waste, abuse, mismanagement or misconduct by CountyCare members, Providers, Personnel or Subcontractors to the HFS OIG within three (3) days after receiving such report.

On an ad-hoc basis, CountyCare Compliance will also submit to HFS OIG:

- Reports regarding any information that may affect a member's eligibility to participate in the Medical Assistance program, including changes in a member's address or death of a member. Reports are provided to HFS OIG within ten (10) business days of receiving the information.
- Reports regarding any information about a change in a Network Provider's circumstances that may affect the Provider's eligibility to participate in the Medical Assistance Program, including termination of the Contractor's Provider agreement. Reports are provided to the HFS OIG within ten (10) business days of receiving the information.

Where required by law or contract requirements, CountyCare Compliance may directly disclose instances of potential FWA to appropriate government agencies through the Compliance Department, HFS OIG, or General Counsel.

Corrective Action, Sanction, Prosecution and Recovery

If an investigation leads to the discovery of behavior that is objectionable, but does not rise to the level of FWA, non-legal corrective action may be commenced. Implementation of the appropriate corrective action is necessary and required. Corrective action may also include including prosecution and recovery. Corrective Actions shall include, but not be limited to the following:

Provider Education: If an investigation finds no credible allegation of FWA but some coding or billing errors made by the provider, CountyCare SIU may elect to educate the provider on mistakes made and monitor changed behavior.

Prepayment Review: In the event that CountyCare subjects a Network Provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to CountyCare considering it for payment as a result of suspected FWA, CountyCare shall adhere to the following within ninety (90) days of requiring such action:

- Conduct a medical and coding review on the claims subject to prepayment review. When FWA is still suspected after conducting the review, CountyCare should submit to the HFS OIG a suspected Fraud referral, including all referral components as required by the HFS OIG.
- A prepayment review shall not be conducted for a Provider listed as under investigation or litigation involving the federal or state government or other circumstances as deemed appropriate by the HFS OIG.

Payment Suspension: Where appropriate, CountyCare may elect to hold payments to a provider while an investigation is ongoing, as long as the provider is not on a Stand Down order or under deconfliction orders from HFS OIG.

Recovery: CountyCare Compliance, in conjunction with its SIU partners, has internal policies and procedures to identify and recover overpayments due to FWA within the timeframes specified by the County MCCN Contract and determined by the HFS OIG. CountyCare will promptly report any overpayments made to a Subcontractor or Network Provider to HFS OIG. Additionally, CountyCare will notify HFS OIG of any overpayment identified through FWA detection, or for which recovery is prohibited. CountyCare shall not take actions to recover FWA related overpayments without written authorization from HFS OIG.

CountyCare Compliance is prohibited from taking any actions to recover or withhold improper payments paid or due to a Network Provider when the specific dates, issues services or claims upon which the recovery is based on meet one or more of the following criteria:

- The improperly paid funds have already been recovered by the State of Illinois, either by HFS or the HFS OIG directly or as part of a resolution of a federal or state investigation or lawsuit, including but not limited to False Claims Act cases; and/or
- When the issues, services, or claims that are the basis of the recovery or withhold are currently being investigated, audited, within the recovery process by the state, or are the subject of pending federal or state litigation or investigation.

In the event CountyCare recovers or otherwise obtains funds in cases where overpayment recovery is prohibited, CountyCare Compliance shall notify HFS OIG and take all action in accordance with written instructions from HFS OIG.

Network Admission or Termination: CountyCare may elect to terminate a provider from its network where an investigation leads to the discovery of actual or suspected fraud. Additionally, investigation findings related to out of network providers may be used to determine whether or not to allow an out of network provider into the CountyCare network.

Recipient Restriction Program (Lock In Program): Where an investigation concludes that a member may not be utilizing their Medicaid benefits appropriately (for example, pharmacy, durable medical equipment, medications, medical supplies, appliances, equipment, and other health care services), the member may be assigned to the Recipient Restriction Program to help control utilization of benefits for the member. Monthly reports regarding members who have been reviewed for lock in program participation are provided to HFS OIG using the mode of communication and/or reporting mechanisms requested by HFS OIG.

Prosecution: If an investigation leads to the discovery of actual or suspected fraud, the suspected fraudulent behavior shall be reported immediately to the appropriate regulatory agency. CountyCare is committed to assist the regulatory agency in any way possible to resolve the matter.

Disciplinary Action: Personnel who are found to be hindering or obstructing an ongoing investigation will face severe disciplinary action, including possible termination.

During an investigation, all Personnel shall be notified of a hold on the destruction of any documents. Any Personnel found to be destroying documents while a hold is in effect will face disciplinary measures up to and including termination and possible criminal penalties.

Personnel may be asked to testify in the event the regulatory agency prosecutes any suspected fraudulent behavior. Personnel should then contact the Compliance Officer, who will seek immediate further guidance from legal counsel.

Sanction by HFS or HFS OIG: HFS OIG may deny, suspend, or terminate eligibility of any person, firm, corporation, agency, institution or other legal entity to participate as a vendor of goods or services to recipients under the medical assistance program under Article V of the contract with HFS, or may exclude any such person or entity from participation as such a vendor, and may deny, suspend, or recover payments, if after reasonable notice and opportunity for a hearing HFS finds:

- The entity is not complying with the Department's policy or rules and regulations, or with the terms and conditions prescribed by the Illinois Department in its vendor agreement.
- The entity has knowingly made, or caused to be made, any false statement or representation of a material fact in connection with the administration of the medical assistance program.

Provider sanctions may include denial, suspension, termination, or exclusion.

In general, under federal law, no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by an excluded individual.[1]

Responses to State and/or Federal Reporting & Investigation Requests

CountyCare Compliance is contractually obligated to receive and respond to communications received from HFS OIG, both regularly (e.g., monthly), as well as on an ad hoc basis.

Types of communications received from HFS OIG include several types of Provider Alerts, which impact the various types of providers used to provide benefits and services to CountyCare members, including Providers, (Medical, Dental, and Vision), Pharmacies, Durable Medical Equipment, Skilled Nursing Facilities, Homemakers and Non-Emergency Transportation providers. Upon receipt, CountyCare will review and ensure compliance with the various types of Provider Alerts including Active Investigation (Deconfliction) Notices, Payment Withholds, Payment Suspension, Payment Suspension Releases, Termination Notices, Disenrollment Notices, Voluntary Withdrawals or Reinstatement Notices. When relevant, Provider Alerts will also be shared with delegated vendor partners and/or SIUs. All Provider Alerts that are labeled as confidential will be treated as such.

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

Requests for information typically have a short turnaround time of between 48 hours and a few weeks and are centered on information related to specific providers are specific situations. CountyCare will diligently review the request and partner with the appropriate SIU benefit administrator to ensure timely and accurate responses are provided to HFS OIG. Audit requests are lengthier data requests from HFS OIG and their partner governmental organizations which require CountyCare to review the request, partner with the appropriate SIU benefit administrator and oversee, conduct and validate the audit scope and findings. These requests typically have a turnaround time of three to six months and may require varying levels of detail.

Upon completion of a review, HFS and HFS OIG guidance will be followed for reporting purposes. If a state or federal agency requests additional information or information regarding another provider, CountyCare will respond in a timely manner.

CountyCare and our subcontractors will cooperate fully with OIG, including in any investigation, whether criminal, civil, or administrative, by a government agency, including OIG. CountyCare, and our subcontractors, and providers must provide data to OIG to support verification activities, substantiate data validation reviews, and reconcile any anomalies in the system.

[1] See 42 CFR §1001.1901(b)(1); 305 ILCS 5/12/4.25(E)(1); 89 Ill. Adm. Code 140.15.

Confidentiality

Reviews are considered confidential regardless of how the issue under review was identified. CountyCare Compliance and its delegated SIU/FWA teams will only discuss a review with other health plan representatives and/or individuals who may have direct knowledge of the potential area of concern or those individuals with FWA oversight responsibility. All communications from HFS OIG and its partner governmental agencies that are labeled as confidential will be treated as such.

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

ATTACHMENT #3

Audit and Compliance Committee

Internal Audit

April 19, 2024

COOK COUNTY HEALTH

Internal Audit

Open Meeting

Internal Audit Charter

COOK COUNTY HEALTH

Internal Audit Charter

- Best practice suggests Boards review and approve their Internal Audit (IA) function's charter annually
- The following slides summarize guidance from the Institute of Internal Auditors (IIA) relating to governance and implementation of the IA charter
- The CCH IA charter is included in the materials provided to the Audit and Compliance Committee (ACC) members
- There are no updates to the charter reviewed and approved in 2023
- We are asking the ACC members to review and approve IA's charter

Internal Audit Charter

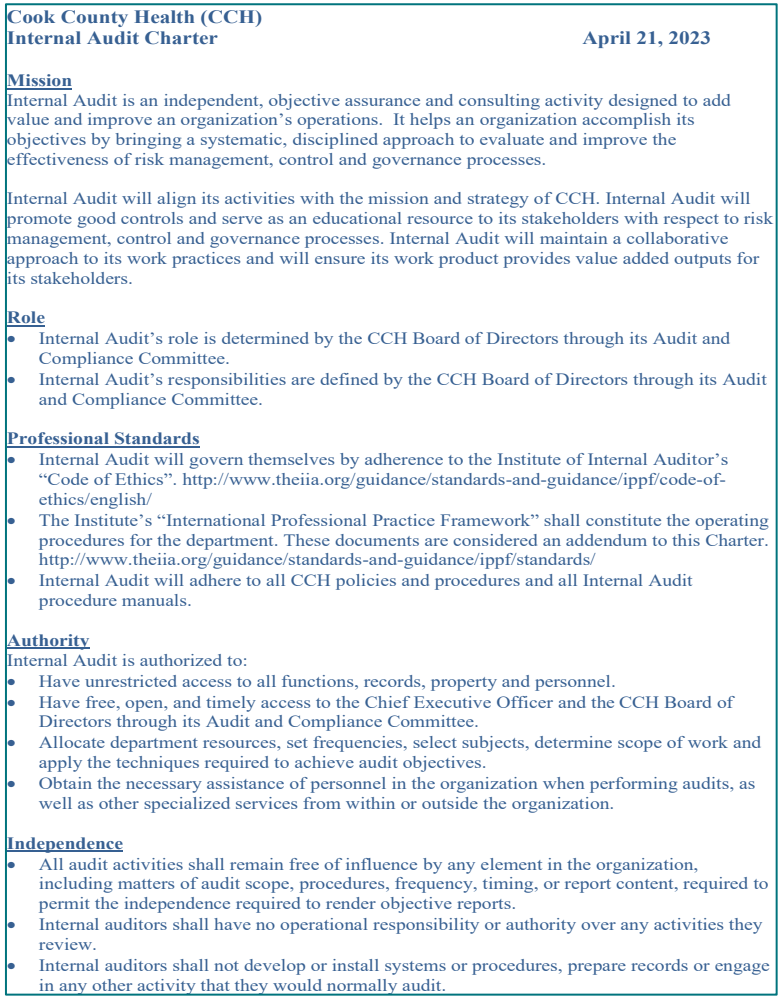
(The following 3 slides are excerpts from the Institute of Internal Auditors (IIA) Practice Standards)

INTERNATIONAL 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.**



Cook County Health (CCH)
Internal Audit Charter **April 21, 2023**

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
- Internal Audit will govern themselves by adherence to the Institute of Internal Auditor's "Code of Ethics". http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/
- 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 content, required to 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 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.

COOK COUNTY HEALTH

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

ATTACHMENT #4

Cook County Health (CCH)
Internal Audit Charter **April 21, 2023**

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

- Internal Audit will govern themselves by adherence to the Institute of Internal Auditor's "Code of Ethics". http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/
- 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 content, required to 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.

APPROVED

APR 26 2024

BY BOARD OF
DIRECTORS OF THE COOK COUNTY
HEALTH AND HOSPITALS SYSTEM

_____
Joseph M. Harrington
Audit and Compliance Committee Chair

_____
Israel Rocha Jr.
Chief Executive Officer

_____
Tom Schroeder
Director of Internal Audit