CountyCare Compliance Program

Annual Report
County Fiscal Year 2021
December 1, 2020 – November 30, 2021

January 21, 2022

Table of Contents

I. Executive Summary

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

The Cook County Fiscal Year ("CFY") 2021 CountyCare Compliance Program Annual Report summarizes the compliance activities carried out in CFY 2021, as well as identifies priorities for CFY 2022.

This past fiscal year, CountyCare Health Plan ("CountyCare") accomplished many goals and implemented a variety of initiatives despite several hardships and challenges. The Cook County Health Corporate Compliance Program ("CCH Compliance") dedicated to CountyCare was directly involved in each major initiative to ensure execution adhered to and incorporated relevant regulatory directives and contractual requirements. Some achievements include:

- Selection of a New Designated Compliance Officer
  CCH Compliance brought on both a new Chief Compliance Officer and new designated Compliance Officer for CountyCare. Both onboarded at the end of September 2021. The new CountyCare Compliance Officer will provide CountyCare with consistent and stable Compliance leadership going into the new fiscal year and beyond.

- CountyCare Remained the Largest Medicaid Health Plan in Cook County
  At the close of CFY 2021, CountyCare remained the largest Medicaid Health Plan in Cook County for the fourth year in a row. As of December 2021, CountyCare covered more than 422,000 lives. Membership growth continues on an upward trajectory with 9,400 new enrollees joining CountyCare in December 2021 alone. This growth is aided by the State of Illinois increasing auto-enrollment of 50% of incoming Medicaid recipients to CountyCare because of CountyCare's excellent quality of care score.

- COVID-19's Continued Impact
  CountyCare continued to provide a comprehensive COVID-19 response through the second year of the COVID-19 pandemic. Partnering with CCH, this included a national award-winning multimedia advertisement and education campaign, standing up one of the nation's largest community COVID-19 vaccination programs, administering more than 918,000 doses, implementing COVID-19 vaccine incentives, continuing targeted member outreach, home delivered meals program, patient monitoring, developing a flexible housing pool benefit, enhanced transportation, etc.

- Proactive Monitoring and Auditing
  CountyCare Compliance identified opportunities to become more proactive in its monitoring and auditing of potential fraud, waste, and abuse. This included being more involved at the initial contracting level and strongly partnering with the Delegated Vendor Oversight team to audit vendors and their compliance programs. These efforts allow CountyCare Compliance to continue focusing on maintaining adherence to contractual

requirements and healthcare compliance best practices as the program continues to mature and be a publicly recognized brand.

- Collaboration with Special Investigation Units ("SIUs") for Payment Integrity Initiatives
  CountyCare Compliance Program Integrity activities resulted in a total of approximately $1.7 million collected in overpayments in state Fiscal Year ("SFY") 2021 and proactively prevented $3.37 million in losses. Recovery amounts continue to be impacted by the recoupment hold put in place at the onset of the Public Health Emergency ("PHE") and the implementation of prior approval processes by HFS OIG for all recoupment activity. Approximately $8.3 million in pending recoveries will be processed by CountyCare's SIU in CFY 2022 that were identified during the August 2020 – August 2021 timeframe using data mining and clinical audits.

- Supported planning and initial implementation of MMAI line of business
  Continuing with its growth trajectory, Health Plan Services is exploring the possibility of adding a new MMAI line of business to help streamline continuity of care for certain eligible member populations. While MMAI is subject to different laws, regulations, and rules, CountyCare Compliance has actively worked with CountyCare leadership and operational staff to support the potential future line of business.

- Strengthened Relationship with State Partners
  In 2021, Illinois Department of Healthcare and Family Services ("HFS") Office of the Inspector General ("OIG") transitioned to new leadership under Inspector General Brian Dunn. CountyCare continues to develop and foster an excellent relationship with state partners and look forward to the new perspectives and processes Inspector General Dunn will implement.

In CFY 2022, 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 continue to build upon and mature under the direction of new leadership. CountyCare Compliance also recognizes the significant support from CCH Compliance and will continue to resume functions CCH Compliance supported exclusively in CFY 2020 and a majority of CFY 2021. 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 CFY 2022 include:

- CountyCare Compliance Officer Onboarding
  Training and continued onboarding of the new designated Compliance Officer for CountyCare and increased effort to locate additional resources for CountyCare Compliance to better concentrate on initiatives designed to improve the Compliance Program, Program Integrity, and compliance presence for CountyCare operations.

- Workforce Education and Compliance Training
  Increase CountyCare workforce education and knowledge regarding CountyCare Compliance'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 Partnerships with Special Investigation Units ("SIUs") for Payment Integrity Initiatives
  Continue to strengthen processes for Program Integrity oversight in the areas of fraud, waste, abuse, mismanagement and misconduct (collectively, "FWA"), in collaboration with vendor partners. A key priority in CFY 2022 will be the continued recovery of claims from the HFS OIG preliminary claim recovery hold due to the PHE.

- Increase collaboration with key stakeholders
  Strengthen and enhance collaboration with CountyCare Delegated Vendor Oversight program to develop more comprehensive and strategic annual compliance related audits of vendors. Additionally, continue to work collaboratively with HFS, HFS OIG, non-government organizations and other Managed Care Organizations' SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.

- Improved reporting
  As an organization with a highly delegated operational model, nimble, efficient, reporting is crucial for strong governance and oversight. CountyCare Compliance will review and leverage existing and new systems and tools to improve the quality of reporting across the various delegated partners with whom CountyCare has relationships.

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

[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 HHS OIG Compliance Guidance documents linked here.

ongoing commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, contractual requirements, CCH policies, procedures, and Code of Ethics.

This Annual Report presents the activities during County Fiscal Year ("CFY") 2021 covering December 1, 2020 through November 30, 2021. Effective late-September 2021, CountyCare Compliance is under the executive leadership of Nicole Almiro, Chief Compliance & Privacy Officer, Ashley Huntington, Privacy Officer, and John Tao, Compliance Officer, CountyCare, with outgoing Chief Compliance & Privacy Officer and Interim CountyCare Compliance Officer Cathy Bodnar's departure in November 2021. Cathy Bodnar's years of service and dedication to CCH is highly admired and will be greatly missed. CountyCare Compliance functions are supported by two (2) Compliance Analysts from CCH Compliance. CCH and CountyCare Compliance continues to engage external compliance consultants from Strategic Management, LLC to assist with critical CountyCare projects, support leadership transitions, and temporarily fill staffing openings, as necessary, for CCH and CountyCare Compliance.

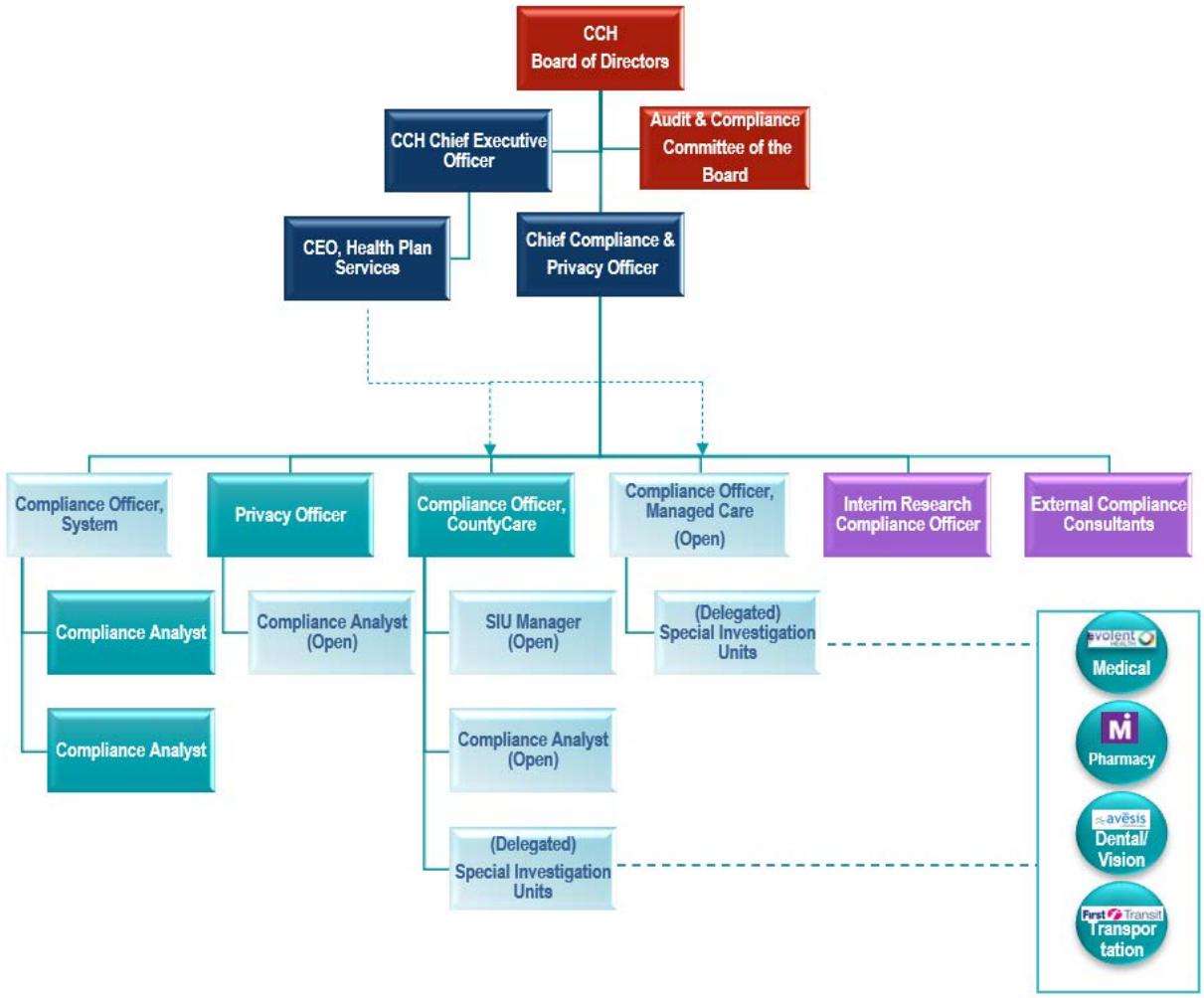
III. Building Blocks – Program Infrastructure and Scope

This Annual Report begins with a look at the structure and activities of CCH and CountyCare Compliance generally, which includes the infrastructure supporting a comprehensive compliance program for CountyCare and its affiliates.

CountyCare Compliance Program Infrastructure

The current CCH Compliance Departmental Organization Chart appears below.

CCH Compliance Organization Chart



Adequate resourcing for the CountyCare Compliance Program remained a significant challenge in CFY 2021 and will continue to be a priority in CFY 2022. Excitingly, the Compliance Officer, CountyCare role was finally filled at the end of September 2021. However, due to CFY 2020 CCH budget staff reduction, and CCH Compliance having eliminated two Compliance Analysts positions, continued CCH and CountyCare Compliance resource strain remains a significant challenge. Four CCH Compliance positions remain open at this time (see chart, above). Efforts to fill open positions are a critical priority for CCH Compliance in CFY 2022.

Due to significant staffing shortages, CCH Compliance continued its interdepartmental workload redistribution, with a majority of CountyCare Compliance issues being exclusively managed by CCH Compliance during CFY 2020 and the majority of CFY 2021. Specifically, CCH Compliance continued managing all Privacy related issues for CountyCare, including: breach analysis and notification; data sharing requests and guidance; subpoena and subrogation requests; Provider Alerts and Stand Down Notices; and, both coordinated and participated in regular leadership,

delegated vendor, and CountyCare regulator meetings. CCH Compliance also continued its engagement with longtime department consultants, Strategic Management, LLC to assist with critical CountyCare and Privacy projects and support the overall success of CCH Compliance. Consultants from Strategic Management continue to provide staffing support for the department while a longer term, sustainable, option is considered. With a new CountyCare focused Compliance Officer onboarded, emphasis has been prioritized on continuing to fulfill the comprehensive slate of required FWA audit, investigation, and reporting responsibilities mandated by the Program Integrity provisions of the MCCN agreement; where possible, CountyCare Compliance also engaged in identifying and addressing CountyCare Compliance related issues as reported, in both a proactive and reactive manner.

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

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 (collectively "FWA");
- Protect CountyCare members, providers, CCH, the State, and the taxpaying public from potentially fraudulent and/or unethical activities;
- Respond and provide guidance related to privacy, confidentiality, and potential or actual security breaches;
- Provide high level oversight to CountyCare's Grievances and Appeals Program; and,
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

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;
- Contracts/Agreements;
- Fraud, Waste, Abuse, misconduct and mismanagement;
- Member Privacy, Confidentiality, and Security;
- Quality; and,
- Regulatory/Policy.

Further, the CountyCare Compliance 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 methods;
- 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, especially in light of significant staffing challenges. It is designed to accommodate future changes in regulations and laws and may be updated to address issues not currently covered, issues related to new service offerings, or regulatory requirements.

IV. Continued COVID-19 Related CountyCare Compliance Activity

As the COVID-19 pandemic continued through its second year, CountyCare Compliance continued supporting CountyCare operations and membership to address the lingering impacts of the pandemic. Notably, CCH Compliance was tasked with serving as a resource for CountyCare to monitor, interpret, and provide guidance on the rapidly changing regulatory landscape, particularly as related to updates communicated from state and federal agencies and departments. Specifically, CCH and CountyCare Compliance continued to monitor regulatory status of paused programs during the Public Health Emergency ("PHE") and helped provide support as programs started to resume.

Examples of the types of essential topics addressed by CCH and CountyCare Compliance related to COVID-19 include, but are not limited to:

- 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.
- Partner with provider groups, specifically long-term care facilities, to provide webinars to educate members, CCH, and Cook County Department of Public Health ("CCDPH") Equity and Priority-Based Vaccination Sites in the community.
- Continued communications for members and providers to accurately explain the CountyCare Task Force efforts and helpful COVID-19 related resources.
- Resuming and managing the backlog of routine record requests and other Special Investigation Unit ("SIU") and Program Integrity activities paused during the initial onset of the COVID-19 crisis and the PHE.
- Interpretation and impact of notifications received from state and federal agencies regarding delays in implementation of various programs or initiatives that were set to roll out during CFY 2021.

- Continued assessments of permissibility of providing CountyCare members with helpful resources, including Wellness Kits, monetary incentives, and enhanced plan benefits, during COVID-19 and the PHE.

While the COVID-19 pandemic remediation efforts continue, outreach to CountyCare membership to take appropriate preventative measures during this ongoing pandemic and PHE are encouraged and supported by CCH and CountyCare Compliance in partnership with CountyCare operations. Steps taken related to each of these issues were essential to ensure CountyCare operations continued in line with state and federal regulator expectation. Additionally, the continued 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 CFY 2022 due to the rise in variants such as Delta and Omicron.

V. Annual Compliance Program Activity – Performance of the Elements

This section of the report serves to summarize activities performed by CountyCare Compliance in CFY 2021 and demonstrate the effectiveness of the program, using the seven 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] However, as noted previously in this Annual Report, staffing shortages, among other challenges, has limited CountyCare Compliance's scope during this fiscal year.

Element 1:

An effective compliance program maintains and distributes a written Code of Ethics, as well as written policies and procedures, that promote the health plan's commitment to compliance with all applicable requirements and standards related to program integrity and that address specific areas of potential fraud, waste, abuse, mismanagement or misconduct.

The CCH Code of Ethics applies to all CountyCare personnel and includes but is not limited to, volunteers, independent contractors, consultants, business partners, providers, agents and subcontractors. The Code of Ethics, as well as CCH's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements. CountyCare also maintains a Compliance Plan demonstrating its commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and Code of Ethics/Standards of Conduct.

[2] 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.

Policies and Procedures

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

- Reviewed and revised the CountyCare Compliance Plan and multiple CCH Compliance and CountyCare health plan policies and procedures to ensure alignment with changes made to CountyCare's contractual and legal requirements, as well as best practices.
- Developed additional CountyCare Compliance internal policies and procedures related to processes for reporting FWA to HFS OIG.
- Partnered with the Delegated Vendor Oversight team and conducted annual audit of CountyCare's delegated vendors to ensure adherence to CountyCare's policies and procedures and MCCN requirements related to Program Integrity.
- Reviewed, revised, and continued to abide by the CountyCare Compliance Plan specifically outlining 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 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 CCH Compliance, worked with CountyCare leadership and 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:

- <u>Interoperability and Patient Access</u>
  Collaborated with CountyCare Project Management Office ("PMO"), leadership, and operations to review requirements of Interoperability and Patient Access final rule and provided guidance related to member authorization and access requirements throughout the implementation process.

- <u>Contract Review</u>
  Provider Contracting and CountyCare Compliance created a process to ensure appropriate FWA checks were performed for potential Network Providers. By integrating compliance within the contracting process, it ensures continued

confidence in the quality and regulatory compliance of Network Providers who newly contract with CountyCare.

- RFP Engagement
  To ensure proactive compliance by design measures, CCH Compliance developed a comprehensive listing of compliance responsibilities related to its Medicaid line of business for inclusion in relevant RFPs and became a voting member during multiple RFP processes to ensure its scoring of prospective business partners would be a strong consideration by the business.

- Audit Protocol Enhancement
  CountyCare Compliance reviewed annual certification requirements of its vendors and subcontractors and identified opportunities to become more proactive in its review and audit. In CFY 2021 CountyCare Compliance partnered closely with the Delegated Vendor Oversight team during their operational audits and included compliance scoring.

- Recipient Restriction (Lock In) Program ("RRP")
  Continued to provide guidance and reviewed revisions to policies and procedures addressing RRP processes, including how members are enrolled in the Proactive and Reactive Lock-In Programs, communications made to members/providers regarding lock in changes and the process for monitoring program progress to CountyCare Pharmacy and Quality departments.

- Documentation Standards for Health Records Policy
  Collaborated with SIUs to establish and publish requirements related to provider signature requirements, cloning occurrences in medical records, and extender billing.

- Provider Readmissions Policy
  CountyCare Compliance collaborated with CountyCare Clinical Operations to help develop and review a policy related to the identification of member acute care readmissions to ensure compliance with HFS regulations and directives.

- Flexible Housing Pool Benefit
  CountyCare Compliance, the Privacy Officer, Cook County Health, Director of Clinical Services, CountyCare and other CountyCare clinical staff continued collaboration to structure and implement a flexible housing pool benefit for CountyCare 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. CCH and CountyCare 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.

- Introduction of a Medicare-Medicaid Alignment Initiative ("MMAI") Health Plan
  Closely partnered with Health Plan Services department, specifically the Project Management Office, to identify and address compliance related responsibilities for the application to launch an MMAI plan offering in CFY 2023.

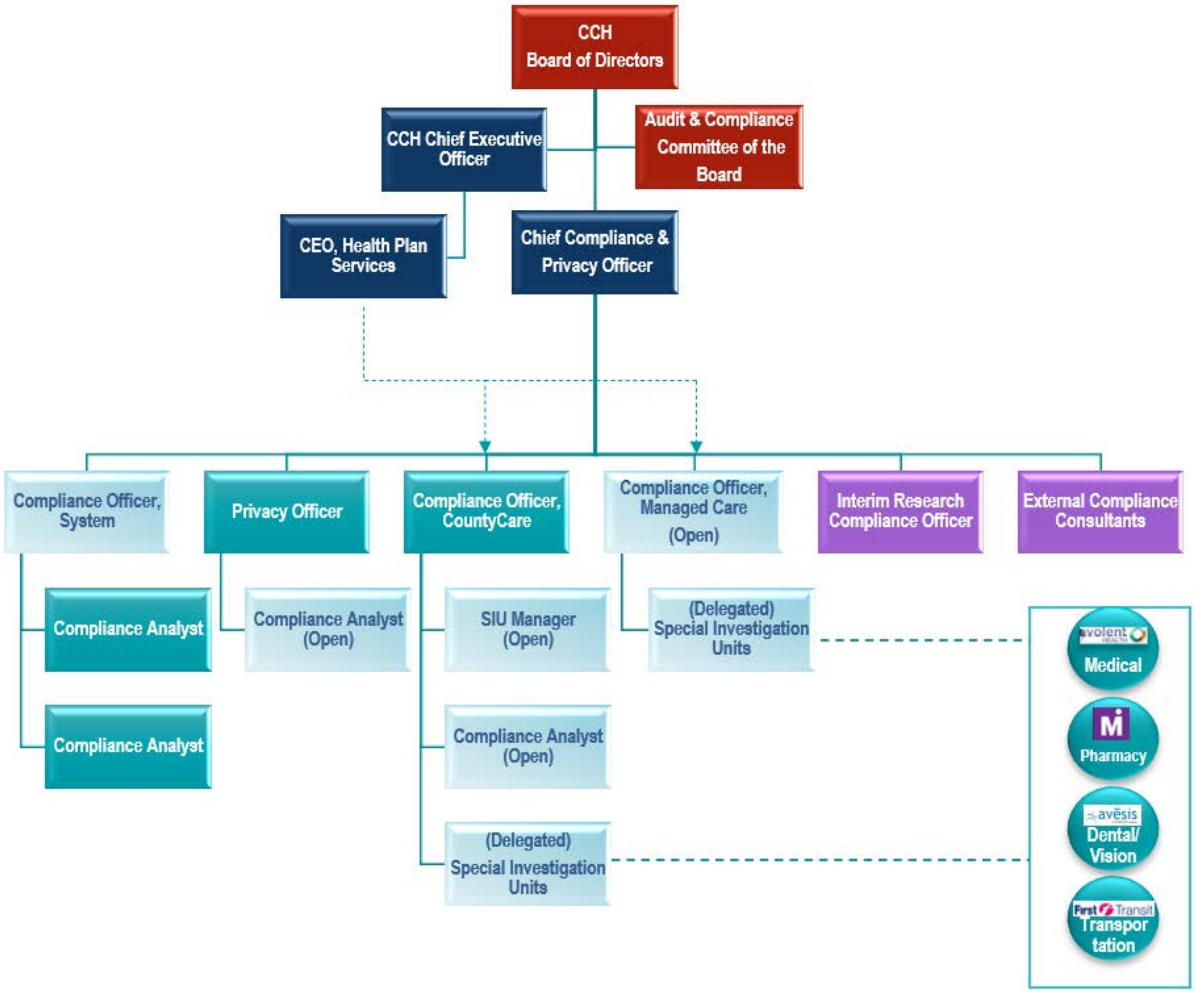
- System Access Tracker
  Continued process for biannual monitoring of system access separate and distinct from CCH systems access as the CountyCare workforce accesses multiple external resources that contains sensitive information including member protected health information, by example through Third Party Administrators ("TPAs").

Element 2

An effective compliance program is led by a Chief Compliance Officer, who reports directly to the organization's Chief Executive Officer and the Board of Directors, 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

Nicole Almiro, the new Chief Compliance & Privacy Officer, onboarded at the end of September 2021, 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 CCH Compliance.



In CFY2021 the Compliance Officer, CountyCare position remained largely open until the end of September 2021 when John Tao joined as Compliance Officer, CountyCare. The past recent Chief Compliance & Privacy Officer, Cathy Bodnar, assumed the primary operational responsibility for CountyCare Compliance in the capacity of interim Compliance Officer, CountyCare until the new Compliance Officer, CountyCare was hired.

For CFY 2021, the primary duties of the Compliance Officer, CountyCare continued to include the following:

- Governance of the Health Plan's Fraud, Waste, Abuse, Mismanagement and Misconduct Program (collectively, "FWA") and Special Investigations Units ("SIUs") to ensure Program Integrity efforts are actively administered.
- High level oversight of the Health Plan's complaint, grievance, appeals and the fair hearing processes for program compliance, including review of trends and patterns through reports and data analysis.

- Ensures 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 non-compliance and potential Program Integrity issues without fear of retaliation.
- Reviews CountyCare agreements, contracts, addenda, and other relevant documents, as needed.
- Aligns with operational management of CountyCare's sanction/exclusion check to ensure that providers, management, workforce and independent contractors are screened against applicable Federal and state sanction and exclusion lists, where and when necessary.
- Coordinates potential Program Integrity investigations/referrals with the SIU, where applicable.
- Partners with other health plans, HFS, HFS OIG, Medicaid Fraud Control Units ("MCFU"), commercial payers, and other organizations, where appropriate, when a potential FWA issue is discovered involving multiple parties.
- Collaborates with leadership to facilitate operational ownership of compliance.
- Synchronizes system-wide compliance program materials and messaging to present a uniform approach consistent with CCH Compliance.
- Oversees, directs, delivers, tracks, or ensures delivery of compliance training, both global and specialty, for employees, Network Providers, 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.
- Ensures Compliance Program reports are produced for the Chief Compliance and Privacy Officer, Chief Executive Officer, Board of Directors, and Audit and Compliance Committee of the Board of Directors.
- Ensures regular reports are produced for the State of Illinois, and all other applicable state and federal governmental entities, as required and requested.

The following committees are tasked with oversight over the CountyCare Compliance Program, as outlined below:

- **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 FWA metrics and assessments of risk areas.

- **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 Regulatory Compliance Committee also reviews CountyCare activity pursuant to Compliance Program requirements and contractual requirements, including, but not limited to audits, monitoring activity, and corrective action plans. The Regulatory Compliance Committee reports through the Chief Compliance and Privacy Officer to the Audit & Compliance Committee of the Board.

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

- **CountyCare Senior Leadership,** a weekly meeting with CountyCare Senior Leadership which rotates topics on a weekly basis focusing on areas such as: Plan Metrics, Project Management Office initiatives and status, Finance Roadmap/MCAP, Strategic Domains such as Staff & Membership Experience/Quality/Health Equity. This weekly meeting is comprised only of CountyCare senior leadership and reviews the health of the Health Plan across all metrics.

- **HFS OIG MCO Subcommittee,** comprised of HFS OIG and Managed Care Organization's ("MCO") compliance members involved in the program integrity functions of their respective MCOs. This subcommittee meets monthly to review and share information regarding FWA activity as it relates to specific providers and trends.

- **Program Integrity Meetings,** comprised of delegated vendors occurring on a 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 CCH Compliance, 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.

- **Grievance and Appeals Committee,** a subcommittee of the CountyCare Quality Improvement Committee ("QIC") 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.

- **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 provides oversight of quarterly delegation audits, monthly joint operations meetings and regular monitoring of member and provider complaints. Identified areas of compliance risk are referred to CCH Compliance and/or CountyCare Compliance for assessment, when appropriate.

- **Pharmacy and Therapeutics Committee** meets quarterly to provide oversight of the pharmacuetical and therapeutic operations to ensure compliance with statutory, contractual, and regulatory requirements such as the member Recipient Restriction Program. The committee also provides oversight of pharmaceutical and therapeutic policies, procedures, and operational procfesses.

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 CFY 2021 due to staff constraints and the lingering impacts of COVID-19. 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 and privacy guidance.
2. CountyCare – HIPAA Training and Guidance for Care Management Staff
   CountyCare Compliance, in conjunction with the CCH Privacy Officer, created an extensive Privacy training for CountyCare Care Coordinators at the request of CountyCare leadership. Training materials were developed over several months and included regular check-in calls with care coordinators to ensure key areas of concern were addressed. The final training deck was delivered to CountyCare Care Coordination in late CFY21. In early CFY22, Privacy will

work with the Care Coordinators on a "train the trainer" arrangement to deliver this training to new Care Coordinators.

3. Targeted Education
   Continued to provide 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 CountyCare Compliance communications (countycarecompliance@cookcountyhhs.org)
   - Monitored Third Party Administrator's ("TPA") 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 CCH 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 Regulatory Compliance Committee, CountyCare Senior Leadership meetings, Audit & Compliance Committee of the Board, and the Managed Care Committee of the Board, as appropriate.

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 **S**ituation, **B**ackground, **A**ssessment, and **R**ecommendation.
   - Initially, CCH Compliance is made aware of a **S**ituation,

    - Contact is made through one or multiple methods e.g., via direct phone call or call through the compliance hotline, e-mail, and/or in-person contact;
    - An inquiry is made, or a concern is described;
    - An individual(s), area(s) or situation is identified.
- This **B**ackground information is categorized, compiled, and logged in the CCH Compliance tracking tool.
- An **A**ssessment occurs,
    - Reviewed and followed contractual obligations, organizational policy, federal, state, and county regulations related to the incident to evaluate the situation presented;
    - Determine what the problem is and/or the severity.
- Lastly, the **R**ecommendation,
    - 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 and appropriate entities.
    - 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 CFY 2021 CountyCare Compliance issues addressed fall within the following categories:

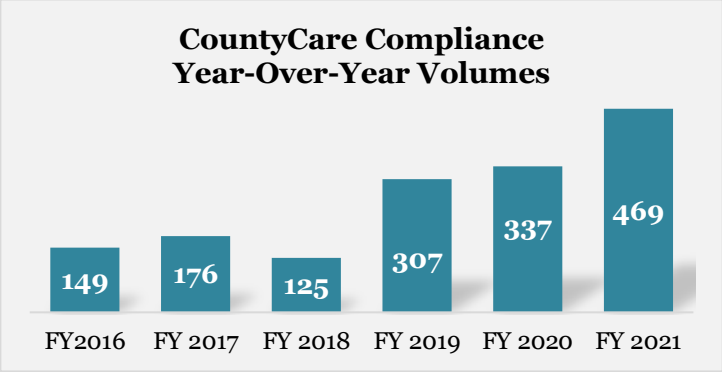
    - Contractual Issues & Reviews;
    - Regulatory/Policy Matters;
    - HIPAA Privacy, Confidentiality and Security;
    - Accurate Books & Records;
    - Fraud, Waste and Abuse;
    - Quality/Patient Safety
    - Conflict of Interest; and
    - Other (e.g., subpoenas, unique grievance & appeals guidance, involuntary discharge of CountyCare member, etc.).

CFY 2021 CountyCare Compliance Contact Volume

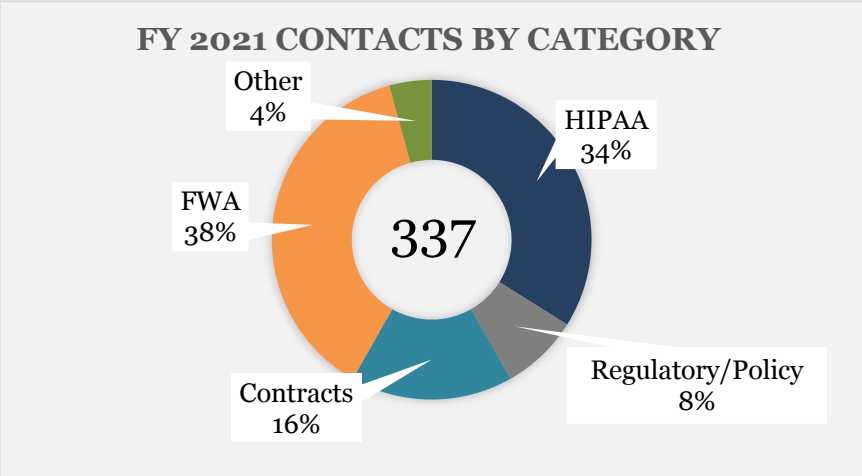
1. Total Volume of General Compliance Contacts

    469 contacts were documented for the CountyCare Compliance Program. The chart that follows illustrates the year-over-year activity, which shows a significant increase of nearly 33% compared to the previous fiscal year. There are several factors which may be attributed to this increase. First, this increase is a result of the continued success of CountyCare, the increasing membership, and variety of new initiatives, including the potential introduction of an MMAI line of business to the Health Plan Services business. Secondly, as CountyCare

becomes a more recognized brand, malfeasance, bad actors, and actions are expected to increase requiring compliance to be more involved in proactively monitoring FWA trends and patterns. Finally, CountyCare Compliance and CCH Compliance currently support subpoena and subrogation requests. Such requests are not a standard compliance function but have seen increasing demand year over year. This year there was a 38% increase in the total number of subpoena and subrogation requests (from 66 to 97). In 2022 compliance will be transitioning these requests to the CountyCare operational team.



2. Inquiry/Issue Breakdown by Category CFY 2021 (December 1, 2020-November 30, 2021)



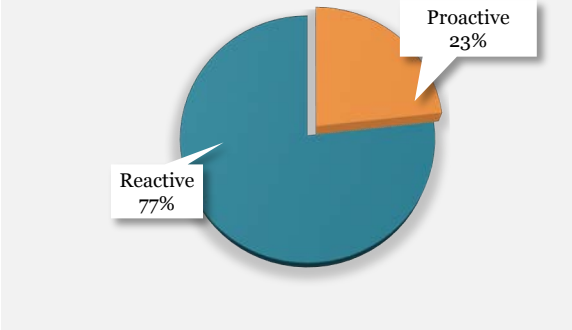
The chart above illustrates the volume of CFY 2021 contacts received by CountyCare Compliance, separated out by issue category. The associated category count follows,

Categories	Count	Categories	Count
HIPAA - Privacy, Confidentiality and Security	159	Contracts/ Agreements	77
Fraud, Waste, Abuse	176	Other	20
Regulatory/Policy	37		

Issue types included in the "Other" category include queries regarding: documentation, conflict of interest, quality/member safety, human resources, and others, as applicable.

3. CFY 2021 Proactive vs. Reactive

Of the 469 CountyCare contacts in CFY 2021, 23% or 109 contacts, were proactive while 77% or 360 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 continues to look forward to increasing awareness of CountyCare Compliance so issues may be addressed more proactively in the coming year, where appropriate resources are available.

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

As a covered entity and business associate of HFS, CountyCare is required to safeguard privacy for plan members. Privacy and security of member information is highly regulated, and this category accounted for 159, or 34% of all CountyCare issues in CFY 2021. As noted in the CCH Compliance Annual Report, CountyCare Privacy is exclusively managed by the Privacy Officer with support provided by CCH Compliance Analysts and external compliance consultants from Strategic Management, LLC.

During CFY 2021, 24 privacy related incidents and breaches were reported to CountyCare Compliance. Incidents occur when, after a risk assessment, it is determined that the event does not rise to the level of a HIPAA breach. A total of seven privacy related contacts rose to the level of a reportable HIPAA breach, which required notification to members. Of the seven breaches, five occurred in relation to activities performed by CountyCare business associates while the remaining two involved CountyCare employees. All employees involved in these breaches, both CountyCare and business associates, were provided additional training as part of mitigation efforts.

The two CountyCare reported breaches involved misdirected communications sent to the wrong individual (for example, mailing a prior authorization letter to an incorrect member or leaving a telephone message for an individual who was not the intended recipient). In both cases, the Privacy Officer notified the affected member and ensured compliance with all regulatory requirements.

Of the breaches caused by CountyCare business associates, two were caused by Evolent due to "bugs" found during system upgrades. One involved an impermissible disclosure of 43 CountyCare members' Protected Health Information ("PHI") to other members through Evolent's Member Portal. The Privacy Officer notified the 43 affected members, along with HFS.

The second instance of an Evolent Member Portal breach was reported to CountyCare by a member. Compliance investigated and collaborated with Evolent to resolve the issue and provide regulatorily required notifications. This breach affected sixty members.

The most significant breach in CFY 2021 involved an impermissible disclosure of 898 CountyCare members' PHI when First Transit, a CountyCare benefit administrator providing non-emergency medical transportation, subcontracted transportation providers not registered with First Transit prior to providing CountyCare members service. As unregistered providers the CountyCare member PHI access these drivers had was impermissible. The Chief Compliance & Privacy Officer and Privacy Officer enforced the contract between Cook County Health and First Transit, requiring First Transit take corrective actions including: terminating their subcontract, notifying affected members, notifying the media, and posting necessary substitute notices.

Additionally, 97 of the contacts included within the HIPAA category reflect activities related to reviewing and processing record requests for CountyCare member records as related to subpoenas and subrogation. These contracts were exclusively managed by CCH Compliance due to CountyCare Compliance staffing shortages through CFY 2020 and a majority of CFY 2021.

Finally, 31 contacts within the HIPAA category reflected guidance or review activities provided by the Privacy Officer and external compliance consultants from Strategic Management, LLC 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, and Abuse, Mismanagement and Misconduct (collectively, "FWA")

A significant amount of time and effort are assigned to the prevention, detection and elimination of FWA by CountyCare Compliance. Of the 469 CountyCare contacts in CFY 2021, 38% or 176 contacts, were related to FWA. More information regarding CountyCare's efforts related to these contacts can be found under Element 6 below, as the majority of these contacts were identified during or resulted in auditing, monitoring or investigation related activities.

Receiving and Responding to Communications from HFS OIG

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

Types of communications received from HFS OIG include several types of Provider Alerts, which impact the various types of providers used to provide benefits and services to CountyCare members, including Providers, (Medical, Dental and Vision), Pharmacies, Durable Medical Equipment ("DME"), Skilled Nursing Facilities ("SNFs"), Homemakers and Transportation providers.

Below is a summary of the volume of Provider Alerts, separated by notice type, received in CFY 2021 from HFS OIG, which CountyCare Compliance then communicated to its relevant SIUs and benefit administrators, as appropriate:

CFY 2021 Provider Alerts	
Active Investigation (also known as "Deconfliction")	12
Payment Withhold	10
Payment Suspension Release	5
Disenrollment, Termination and Voluntary Withdrawal	65
Reinstatement	9
TOTAL	**101**

Additionally, HFS OIG communicates official data requests for information on an ad hoc basis, requiring CountyCare Compliance to collaborate with its SIUs, 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 CFY 2021, CountyCare received and responded to **46** 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

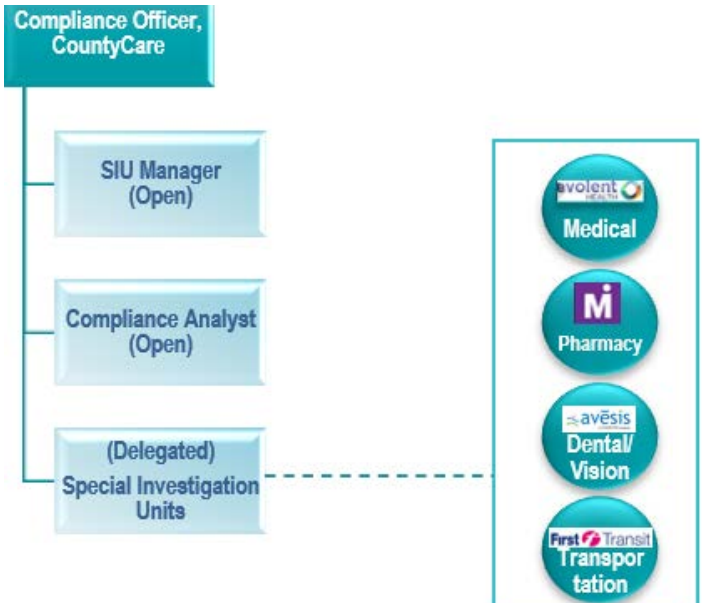
During CFY 2021, CountyCare Compliance exercised and broadened the scope of its enforcement standards through:

- **Investigations and Guidance for Employee Related Corrective Actions.** CountyCare Compliance, via CCH Compliance, investigated employee related complaints (for example, those related to confidentiality complaints or conflict of interest) and provided guidance to involved employees and leadership to remediate the situations and avoid repetition of the incident.

- **Monitoring Corrective Action Plans ("CAPs"), Deficiency Action 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 CFY 2021, CCH Compliance monitored one (1) vendor for improvement based on two (2) compliance related CAPs, DAPs or PIPs.

- **Privacy and Security ("HIPAA") Breach Assessments.** The Privacy Officer maintains consistency in approach for breach assessments and to provide guidance to CountyCare workforce members and business associates.

- **Fraud, Waste, Abuse, Mismanagement and Misconduct (collectively, "FWA") Monitoring.** CountyCare Compliance collaborated closely with the Special Investigation Units ("SIUs") of Delegated Vendors to identify potential FWA. CountyCare continues to work with its SIUs to perform data analytics, including DRG auditing and coding analysis, to identify, investigate and report unusual 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 care organizations and health plans, the HealthCare Fraud Prevention Partnership ("HFPP"), National Insurance Crime Bureau ("NICB"), Midwest Anti-Fraud Insurance Association ("MAIA"), and the professional organization of compliance professionals, Health Care Compliance Association ("HCCA").

Element 6

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

CountyCare Delegated Special Investigation Units

Prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct (collectively, "FWA") 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 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.

To identify potential FWA, 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. CountyCare Compliance is actively pursuing an "SIU Manager" role within the organization to provide additional support and alleviate spend on external consultant partners moving forward in CFY 2022.

Auditing and Monitoring Efforts for SFY 2021

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

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

CountyCare continues to utilize data mining, a proprietary catalogue of concepts developed by its SIUs, to analyze CountyCare claims and identify providers with unusual billing patterns and reviews. CountyCare Compliance also investigates tips received from HFS, HFS OIG, other Managed Care Organizations ("MCOs"), healthcare fraud groups, CountyCare employees, the media, and other sources to identify FWA.

All Program Integrity activity is tracked by State Fiscal Year ("SFY") for state reporting purposes and not by County Fiscal Year ("CFY"). The SFY runs from July 1st through June 30th of each year.

Metrics for both SFY 2021 along with the first quarter of SFY 2022, as reported to HFS OIG on a quarterly basis, follow:

S-FY	Reporting Period	Tips[3]	Referrals to HFS OIG[4]	Overpayments Identified[5]	Overpayments Collected[6]
2021	Q1 07/01 -09/30/20	49	0	$ 1,277,500	$ 196,600
2021	Q2 10/01 – 12/31/20	106	8	$ 1,697,500	$ 304,000
2021	Q3 01/01 – 03/31/21	49	20	$ 1,970,360	$ 713,020
2021	Q4 04/01 – 06/30/21	46	9	$ 1,378,755	$ 485,839

S-FY	Reporting Period	Tips	Referrals to HFS OIG	Overpayments Identified	Overpayments Collected
2022	Q1 07/01 – 09/30/21	100	18	$ 583,637	$ 66,066

The results of the annual Program Integrity activities are reflected in the metrics above with a total of $1,699,412.03 collected in overpayments in SFY 2021. The amount recovered in SFY 2021 was a 104% decrease over the $5,396,934.89 recovered in SFY 2020. There are several reasons for the decrease.

First, the SFY 2021 recovery amount exceeded normal recovery amounts by nearly 170% and should not set the standard for recoveries on a year over year basis. The unique increase in SFY 2021 was driven in part due to the initial approval from HFS OIG to begin recoupment of monies temporarily suspended during the PHE. As discussed previously in this Annual Report, the PHE resulted in a backlog of recoveries due to HFS OIG temporarily suspending recoveries. As the

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

impacts of the PHE decline and a new normal stabilizes a decrease in recoveries from the backlog would be expected.

Second, with revisions to the MCCN Agreement made by the KA2 amendment, new processes were implemented between the State of Illinois and all Managed Care Organizations within the Medicaid program, including CountyCare. HFS OIG now requires all requests for recoupment receive prior approval which has added additional time in the already lengthy recoupment processes. Additionally, due to HFS OIG reporting changes, the numbers reported no longer include recoveries not requiring traditional audit or investigation. Specifically, recoveries related to administrative errors, including data mined activities, are no longer reported to HFS OIG. However, data mining recoveries for Q1 SFY 2022 (July – September 2021) are included in the table above for purposes of this Annual Report. Data mining activities continue to be a significant tool used by CountyCare Compliance to combat FWA.

Third, due to the timing of claim audits and recoveries the PHE continues to have an impact on claim recoupments. Notably, a backlog of approximately 22,500 claims identified using clinical audits at the DRG level during the temporary PHE suspension received HFS OIG approval for recovery within the past year. The volume of claims has led to a sizable backlog requiring a significant amount of recovery effort. These claims total approximately $8.3M CountyCare may expect to recover during 2022. To date, $150K has been recovered of the total projected amount.

CountyCare Compliance continuously monitors the process to ensure appropriate action is taken, including reporting of suspected FWA to HFS OIG. In SFY 2021, CountyCare referred 37-cases to the HFS OIG for possible FWA – an increase of 136%. 18 referrals have been made in Q1 2022 alone, highlighting the increased oversight of CountyCare providers.

- Annual Compliance Audit and Attestation

  CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare's delegated vendors in June 2021. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, compliance with the requirements of Section 9.2 of the MCCN. Additionally, each of CountyCare's delegated vendors completed a compliance audit during CFY2021, which was facilitated through partnership with the Delegated Vendor Oversight audit process.

- Grievances and Appeals Activities

  CountyCare Compliance continues to provide high-level oversight related to grievance and appeals activities at the plan level. As needed, guidance and assistance is provided related particularly to contractual and regulatory timeframes. Additionally, CountyCare Compliance

participates in the quarterly CountyCare Grievance and Appeals Committee, as well as Delegated Vendor Oversight meetings.

Regulator Audit Activity for CFY 2021

CountyCare Compliance held several meetings with new HFS OIG Inspector General Brian Dunn, when he first started his role in early 2021. No official compliance related audit requests were issued by HFS OIG and HSAG during CFY 2021.

Risk Assessment

The primary focus within CountyCare Compliance is prevention, detection and elimination of FWA, in addition to other areas of risk identified in CFY 2021. Risk assessment currently is an ongoing exercise within CountyCare Compliance, performed on a consistent basis by monitoring issues that arise via the various lines of communications offered by the Department as well as in day-to-day communications with CountyCare operations and benefit administrators.

Where resources are available in CFY 2022, CountyCare Compliance will build on the 2021 effectiveness review conducted by Strategic Management Services, LLC and 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 requirements set forth by the MCCN Agreement and the Department of Health and Human Services, Office of Inspector General, to ensure screening of all contractors and workforce members.
- The goal of the policy is to avoid employing, engaging, contracting or agreeing with any individual or entity excluded or "sanctioned" from participation in a federal health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services.
- Sanction screening requirements continue to be embedded within each CountyCare contract and each CountyCare benefit administrator is required to screen each provider in their networks.
- 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, 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 FWA identified that is related to providers/groups enrolled in the HealthChoice 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 Medicaid 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 requires CountyCare Compliance to submit a quarterly FWA report to HFS OIG. This report (also known as the "FWA Tool") must include all instances of suspected FWA, among other Program Integrity data requested, or indicate there was no suspected FWA 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 spent clarifying with HFS OIG the types of Program Integrity related information that should be included within the report. Consequences from such discussions have been reflected in the above section "Auditing and Monitoring Efforts for SFY2021". Discussions will continue into 2022, and beyond, with additional changes likely under Inspector General Brian Dunn's leadership.

  CountyCare Compliance devotes a significant amount of time and effort to develop, review and submit 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. CountyCare Compliance and resources within CCH Compliance collaborated to develop both an internal policy outlining the parameters for developing, reviewing and submitting the required reports listed above to HFS OIG and will leverage existing Salesforce tools to help consolidate data from all the various SIU partners and streamline the reporting process.

Prompt Responses to HFS OIG Data Requests

HFS OIG and its partner governmental agencies, such as the US DOJ, regularly submit data requests to CountyCare for review and completion. These requests can involve a

variety of asks including, but not limited to, claims reviews of specific providers, documentation used for certain billing practices, or any number of items related to the MCO. In CFY 2021 CountyCare received 46 such requests, averaging almost one a week. There are typically two types of requests.

Request for Information

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

Requests for Audit

Requests for audit are lengthier data requests from HFS OIG and their partner governmental organizations which require CountyCare review the request, partner with the appropriate SIU benefit administrator, and oversee 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.

VI. Looking Ahead to CFY 2022

In CFY 2022, CCH Compliance 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 FWA in addition to protecting CountyCare members and providers. The Program will continue ongoing activities related to risk reduction in the areas of compliance, policy implementation, and the development and implementation of monitoring and auditing efforts.

These priorities have been established for the CountyCare Compliance Program:

- Continued training and onboarding of the new designated Compliance Officer for CountyCare 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 CountyCare oversight of FWA Activities:
    - Foster continued partnerships with HFS OIG and the State's MFCU to develop best practices in Corporate Compliance for CountyCare and enhance relationships with non-government organizations and other MCOs' to build a network of skilled investigators and increase effective Program Integrity efforts.
    - Continue efforts to review and approve new concepts for data mining and clinical audit recovery activities.

    - 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 report.
- Continue developing and maturing collaboration opportunities with CountyCare 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.