



CountyCare Compliance Program

Annual Report

Fiscal Year 2020

December 1, 2019 – November 30, 2020

February 19, 2021

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

Table of Contents

I.	Executive Summary.....	3
II.	Introduction	5
III.	Building Blocks – Program Infrastructure and Scope.....	5
IV.	COVID-19 Related CountyCare Compliance Activity.....	8
V.	Annual Compliance Program Activity - Performance of the Elements.....	9
	Element 1 - Standards of Conduct, Policies and Procedures	9
	Element 2 - Compliance Office and Oversight Responsibilities.....	11
	Element 3 - Education and Training.....	15
	Element 4 - Receiving and Responding to Complaints.....	16
	Element 5 - Enforcing Standards.....	21
	Element 6 - Monitoring and Auditing.....	22
	Element 7 – Prevention.....	25
VI.	Looking Ahead to 2021.....	27

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

I. Executive Summary

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

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

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

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

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

initiatives until October 2020 when HFS OIG and Bureau of Managed Care permitted CountyCare Compliance to resume recovery activities.

- HFS OIG Compliance Attestation Completion. In October of 2020, CountyCare Compliance gathered and submitted a substantial amount of information regarding the CountyCare Compliance Program structure, guidance and activities in response to an HFS OIG Compliance Program Review Self-Assessment Questionnaire. No feedback has been provided by HFS OIG.
- Successful Health Services Advisory Group (HSAG) Audit: CountyCare Compliance submitted a large volume of documentation to HSAG, the audit contractor used by HFS for its Managed Care Organizations (MCOs), with respect to review topics addressing Fraud, Waste and Abuse (Standard XIII) and Confidentiality (Standard IX). A virtual review of the health plan was conducted with remote interviews by HSAG on November 12-13, 2020. CountyCare Compliance scored 100% with respect to each of the audit standards reviewed, as reflected in the HSAG final audit report.
- COVID-19 Public Health Emergency: CountyCare Compliance provided continuous monitoring of the changing regulatory landscape in response to COVID-19, as related to the CountyCare comprehensive COVID-19 response (including targeted outreach, home delivered meals program, remote patient monitoring, enhanced transportation, etc.), synthesizing significant regulatory changes and communicating guidance to operational leadership and vendors. Additionally, CountyCare Compliance was integral in monitoring updates communicated via HFS and HFS OIG related to efforts addressing fraud, waste, abuse, mismanagement and misconduct that were impacted by COVID-19.

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

Notable priorities that have been identified for FY 2021 include:

- Selection of a new designated Compliance Officer for the CountyCare health plan (interviews planned for February 2021) and increased effort to locate additional resources for CountyCare Compliance to better concentrate on initiatives designed to improve the Compliance Program, Program Integrity, or compliance presence for CountyCare operations as a whole.
- Increase CountyCare workforce education and knowledge regarding the Compliance Department's duties, the compliance hotline, and a workforce member's duty to report to encourage proactive identification and discussion of issues with the department.
- Strengthen processes for Program Integrity oversight in the areas of fraud, waste, abuse, mismanagement and misconduct, in collaboration with vendor partners.
- Identify and implement opportunities for collaboration with the health plan Delegated Vendor Oversight program to conduct annual compliance related audits of vendors.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Continue to work collaboratively with HFS, HFS OIG, non-government organizations and other MCOs' SIUs to build a network of skilled investigators and increase effective Program Integrity efforts.

II. Introduction

CountyCare is a Managed Care Community Network (MCCN) health plan offered by Cook County Health (CCH) pursuant to a contract with the Illinois Department of Healthcare and Family Services (HFS). Since late 2012, CCH has partnered with the State of Illinois, initially through the State of Illinois federal Section 1115 demonstration waiver which was an early start on Medicaid expansion, then in 2014, CountyCare transitioned into the MCCN. The operation of the CountyCare MCCN is facilitated through CCH and its various subcontractors.

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

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

III. Building Blocks – Program Infrastructure and Scope

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

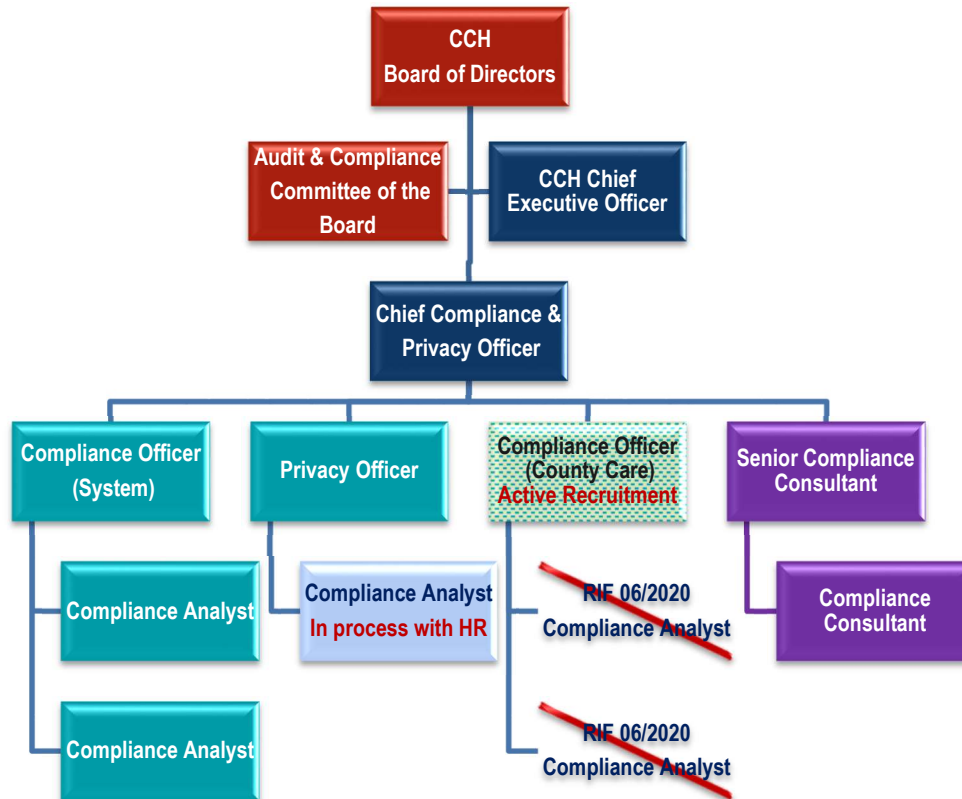
¹ See 42 C.F.R. §438.608 and Section 5.35 of the MCCN Agreement (2018-24-201), as amended by KA2 and KA5 in 2020. See also HHS OIG Compliance Guidance documents linked [here](#).

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

CountyCare Compliance Program Infrastructure

The current Corporate Compliance Program Departmental Organization Chart appears below.

Compliance Organizational Chart



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

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

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

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

CountyCare Compliance Program Scope

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

- Comply with the CMS Managed Care Program Integrity requirements and the terms of the CountyCare Health Plan contract with HFS;
- Prevent, detect and eliminate fraud, waste abuse, mismanagement and misconduct;
- Protect health plan members, providers, CCH, the State, and the taxpaying public from potentially fraudulent activities;
- Respond and provide guidance related to privacy, confidentiality, and security matters;
- Provide high level oversight to the health plan's Grievances and Appeals Program; and
- Understand and focus on high-risk areas that have the greatest potential for non-compliance with federal and state regulatory and contractual requirements.

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

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

Further, the program aims to continually evaluate and strengthen its working communication strategy to increase the CountyCare workforce awareness, including vendors and subcontractors, of the following topics:

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

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

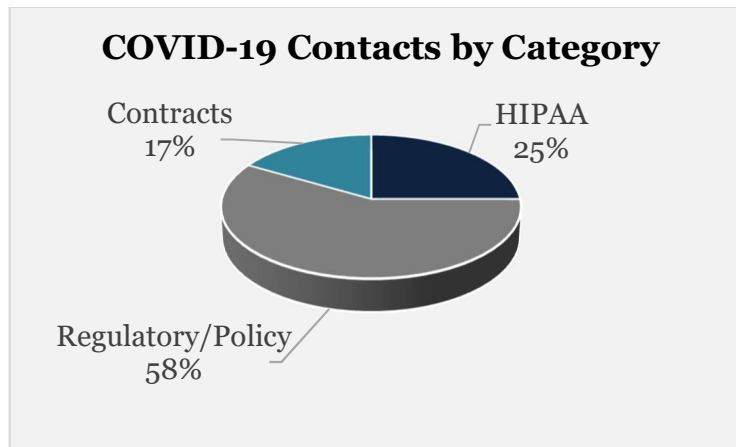
in regulations and laws and may be updated to address issues not currently covered, issues related to new service offerings, or regulatory requirements.

IV. COVID-19 Related CountyCare Compliance Activity

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

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

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



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

- Privacy and security concerns related to sharing and communicating member information, internally and with vendors and providers, for COVID-19 care management and care coordination related purposes.
- Communications for members and providers to accurately explain the CountyCare Task Force efforts and helpful COVID-19 related resources.
- Interpretation and impact of notifications received from state agencies to temporarily suspend routine record requests and other Special Investigation Unit (SIU) and Program Integrity activities during the COVID-19 crisis.
- Interpretation and impact of notifications received from state agencies regarding delays in implementation of various programs or initiatives that were set to roll out during FY 2020 (i.e., implementation of the Integrated Health Home program, Ordering, Referring, Prescribing (ORP) Provider edits).
- Explanations regarding Section 1135 waiver provisions addressing provider flexibilities, urgent appeals and Medicaid fair hearings during the public health emergency.
- Permissibility of providing health plan members with helpful resources, including Wellness Kits and enhanced plan benefits, during COVID-19.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

While the COVID-19 related contacts account for approximately 4% of the total contacts received by the department, steps taken related to each of these issues were essential to ensure that health plan operations continued in line with state and federal regulator expectation. Additionally, the impacts of COVID-19 can be seen through much of the work reflected related to each element of the CountyCare Compliance Program, listed in Section V. below. CountyCare Compliance anticipates providing significant ongoing support on COVID-19 related issues well into FY 2021.

V. Annual Compliance Program Activity – Performance of the Elements

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

Element 1:

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

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

Policies and Procedures

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

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

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.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Developed additional CountyCare Compliance internal policies and procedures related to processes for reporting fraud, waste, abuse, mismanagement and misconduct to HFS OIG, as well as the process for handling Provider Alerts and fulfilling data requests received from HFS OIG.
- Conducted annual audit of CountyCare's delegated vendors to ensure adherence to CountyCare's policies and procedures, as well as the new MCCN contractual requirements addressing Program Integrity.
- Reviewed, revised and continued to abide by the CountyCare Compliance Plan that specifically outlines the compliance responsibilities of the health plan and program design, as well as specific CountyCare compliance policies for high risk areas focused on health plan operations.
- Ensured that CountyCare personnel, providers, agents and subcontractors had access to compliance documentation electronically and were provided with hard copies of compliance policies and procedures upon request.
- Reviewed and/or drafted appropriate compliance contract language for new or updated CountyCare contracts with delegated vendors and providers.

Ad Hoc Activities/Guidance

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

Examples of areas assessed:

- MCCN Contract Amendments (KA2 and KA5) Changes: Contract Amendment 2 (KA2) related to the Program Integrity raised many questions regarding how to implement particular sections. CountyCare Compliance actively reached out to other MCOs, gathered questions, and presented to HFS OIG for clarification.
- Medical and Prior Authorization Policies: Continued to work with CountyCare Special Investigation Units (SIU) to identify areas where prior authorization processes or claims edits could reduce waste, abuse, mismanagement and misconduct for the Medicaid program.
- Provider Manual: Updated the Member Handbook to strengthen language and to reflect updates to fraud, waste and abuse language based on the MCCN Amendment 2 (KA2).
- Recipient Restriction (Lock In) Program: Analyzed, provided guidance and reviewed draft policies and procedures addressing Recipient Restriction Program processes, including how members are enrolled, communications made to members/providers regarding lock in changes and the process for monitoring program progress to CountyCare Pharmacy and Quality departments.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Documentation Standards for Health Records Policy: Communicated with SIUs to research and establish requirements related to provider signature requirements, cloning occurrences in medical records and extender billing.
- Provider Preventable Conditions: CountyCare Compliance collaborated with the Chief Medical Officer and the health plan's third-party administrator (TPA) to develop policies and procedures related to provider preventable conditions. The policies were implemented as the TPA made configuration and analysis delivery available.
- Flexible Housing Pool Benefit: CountyCare Compliance, the Privacy Officer, Cook County Health, Director of Clinical Services, CountyCare and other CountyCare clinical staff collaborated to outline parameters for how to structure and implement a flexible housing pool benefit for health plan members, including how to properly share information across vendors and partners taking consideration current privacy related contract constraints and minimum necessary requirements.
- MoreCare Medicare Guidance: CCH, through its Health Plan Services department, continues to partner with MoreCare to operate a Medicare product. Compliance continues to collaborate with MoreCare Compliance to provide guidance to staff working on both the Medicaid and Medicare businesses regarding the differences in Medicare and Medicaid program requirements and the continued need to segregate CountyCare data from MoreCare data and utilize access controls to maintain appropriate protection of data.
- System Access Tracker: Worked with the CountyCare workforce to continue implementation of a process to monitor system access separate and distinct from CCH systems access. The CountyCare workforce has access to multiple external resources that contains sensitive information including member protected health information, by example through TPAs. A policy and procedure was developed to safeguard member protected health information and confidential material and education was provided to CountyCare workforce.
- Vendor Data Requests: CountyCare Compliance collaborated with health plan operations to ensure that new vendor contracts specifically address the expectation that vendors will handle data requests once the contract ends, and their responsibilities related to historical data transferred from the prior vendor.

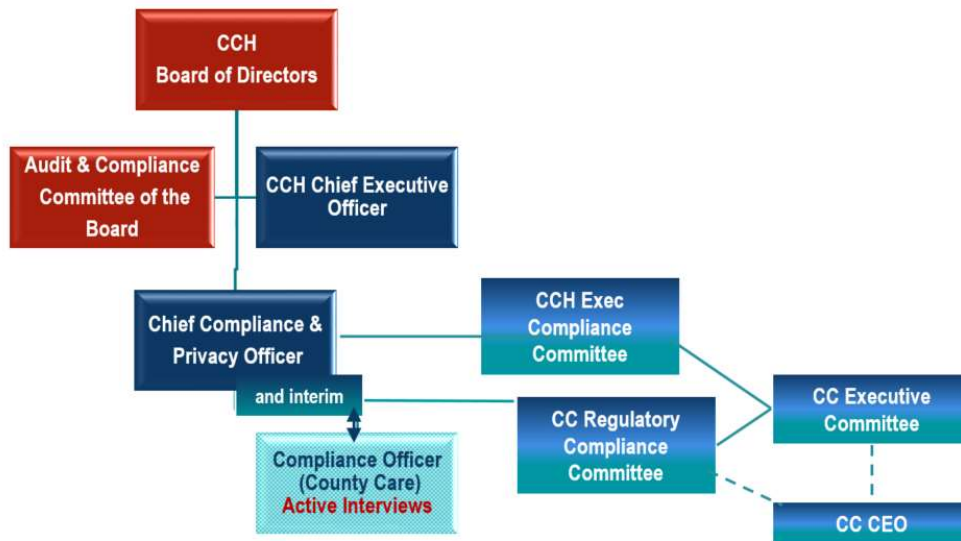
Element 2

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

Compliance Office and Oversight Committees

Cathy Bodnar, the Chief Compliance & Privacy Officer, reports to both the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer. In turn, the CCH Audit & Compliance Committee of the Board and the CCH Chief Executive Officer each report to the CCH Board of Directors. The graphic below illustrates the communication and reporting structure for the CountyCare Compliance program, which is embedded within the CCH Corporate Compliance Program.



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

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

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Ensures that Program Integrity issues are reported in accordance with federal, state and local requirements, as well as the guidelines in the Medicaid Managed Care regulations at 42 CFR §438.608 and the CCH MCCN Agreement with HFS.
- Implements and coordinates communication channels to encourage workforce, employees and independent contractors to report issues related to noncompliance and potential Program Integrity issues without fear of retaliation.
- Reviews health plan agreements, contracts, addenda, and other relevant documents, as needed.
- Aligns with operational management of the Health Plans' sanction/exclusion check to ensure that providers, management, workforce and independent contractors (where necessary) are screened against applicable Federal and state sanction and exclusion lists.
- Coordinates potential Program Integrity investigations/referrals with the SIU, where applicable.
- Partners with other health plans, HFS, HFS OIG, Medicaid Fraud Control Units (MCFUs), commercial payers, and other organizations, where appropriate, when a potential FWA issue is discovered that involves multiple parties.
- Collaborates with operational leadership to facilitate operational ownership of compliance.
- Synchronizes system-wide compliance program materials and messaging to present a uniform approach.
- Oversees, directs, delivers, tracks, or ensures delivery of compliance training, both global and specialty, for employees, providers, volunteers, students, vendors, and consultants.
- Develops, assesses, evaluates, implements, maintains, and updates compliance policies and procedures to ensure adherence with relevant requirements.
- Establishes a structured process for regulatory review, monitoring, and dissemination of information.
- Modifies policies, procedures, and projects to reflect changes in laws and regulations.
- Develops and coordinates compliance projects with CCH system entities and performs prospective reviews in conjunction other personnel as deemed necessary.
- Assures that Compliance Program reports are produced for the Chief Executive Officer, Board of Directors, and the Audit and Compliance Committee of the Board of Directors.

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

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

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

- The **CountyCare Executive Committee** is comprised of CCH senior delegates and CountyCare leadership and is responsible for providing oversight, guidance and support to CountyCare leadership to support the achievement of agreed upon goals in a manner consistent with a provider-sponsored organization. The Committee provides useful feedback to CountyCare leadership regarding Plan performance and promotes alignment between CCH objectives and CountyCare programs. The meeting scope and schedule is currently under re-evaluation by executive leadership considering the COVID-19 impact to operations.
- The **HFS OIG MCO Subcommittee** is comprised of HFS OIG and Managed Care Organization's (MCO) compliance members involved in the program integrity functions of their respective MCOs. This subcommittee meets monthly to review and share information regarding fraud, waste and abuse activity as it relates to specific providers and trends.
- Corporate Compliance **Program Integrity Meetings** with delegated vendors occur on bi-weekly or monthly cadence, depending on the vendor and amount of activity. Led by the Compliance Officer, CountyCare, and attended by other members of the Corporate Compliance department, as needed, the meetings provide an overview of the vendors' activities and serve as a forum to review, approve, modify, or reject the direction of audits, investigations, data mining efforts and recoupment activity.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- **Medical Cost Action Plan (MCAP)** meetings with executive CountyCare leadership held monthly (or more often) to collectively identify and track opportunities for savings across health plan departments and initiatives.
- The CountyCare **Grievance and Appeals Committee** is a subcommittee of the CountyCare Quality Improvement Committee (QIC) and the CountyCare Regulatory Compliance Committee and is responsible for maintaining compliance with contractual, federal, and accrediting body requirements, including NCQA standards, related to the processing of grievance and appeals. The scope of the committee includes tracking and analysis of member grievances and appeals from all delegated vendors including type and timeliness of resolution, performing barrier and root cause analysis and making recommendations regarding corrective actions as indicated.
- The **Delegated Vendor Oversight Committee** meets quarterly to provide oversight of the operations affecting the scope of functions of delegated vendors and subcontractors to ensure compliance with statutory and contractual requirements. The Committee also provides oversight of quarterly delegation audits, monthly joint operations meetings and regular monitoring of member and provider complaints. Identified areas of risk that fall under the purview of Corporate Compliance are referred to Corporate Compliance for assessment.

Element 3

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

Education and Training

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

1. CountyCare – Provider FWA training and New Employee/Contractor Orientation
 - Reviewed and updated provider Fraud, Waste and Abuse training to provide new content related to Program Integrity contract changes.
 - Participated in New Employee training, providing new hires (both permanent and contractual) an introduction to all aspects of CountyCare, with dedicated time for compliance program introduction.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

2. CountyCare – HIPAA Reminder Training

- Corporate Compliance was asked to present on the topic of privacy at CountyCare's regular Lunch and Learn series. During this meeting, Compliance highlighted the basics of HIPAA, including the rules surrounding uses and disclosures of protected health information (PHI), as well as our responsibilities to protect member PHI. Compliance further discussed transport layer security (TLS) connections between CountyCare and its business partners. Finally, systems access was highlighted and staff were introduced to the CountyCare Systems Access Tracker.

3. Targeted Education

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

Element 4

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

Receiving and Responding to CountyCare Related Complaints

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Presented trends and patterns to the CountyCare Compliance Committee, CountyCare Executive Committee, Audit & Compliance Committee of the Board, and the Managed Care Committee of the Board.
2. There are established CountyCare Compliance processes for responding to issues and complaints received. CountyCare Compliance maintains processes for issue, complaint management, and resolution as follows:
- The workflow process for compliance contacts follows SBAR, an acronym for Situation, Background, Assessment, and Recommendation.
 - Initially, Corporate Compliance is made aware of a Situation,
 - Contact is made through one or multiple modalities e.g., via direct phone call or call through the compliance hot line, e-mail, and/or in-person;
 - An inquiry is made, or a concern is described;
 - An individual(s), area(s) or situation is identified.
 - This Background information is classified, compiled and logged in the Corporate Compliance tracking tool.
 - An Assessment occurs,
 - 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 Recommendation,
 - Establish a pathway for mitigation and remediation. These may include further auditing of documentation, mitigating harm, and potentially informing the appropriate government entity.
 - This always involves engaging and collaborating with leadership 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 issues addressed within the past fiscal year of CountyCare Compliance addressed the following categories:
- Contractual Issues & Reviews;
 - Regulatory/Policy Matters;
 - HIPAA Privacy, Confidentiality and Security;
 - Accurate Books & Records;
 - Fraud, Waste and Abuse;
 - Quality/Patient Safety
 - Conflict of Interest; and

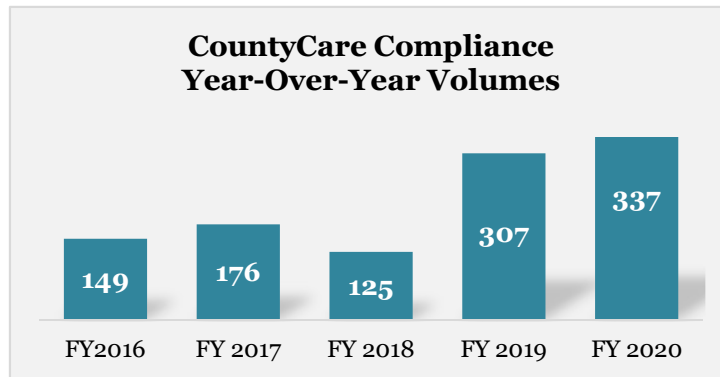
Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Other (e.g., subpoenas, unique grievance & appeals guidance, involuntary discharge of CountyCare member, etc.).

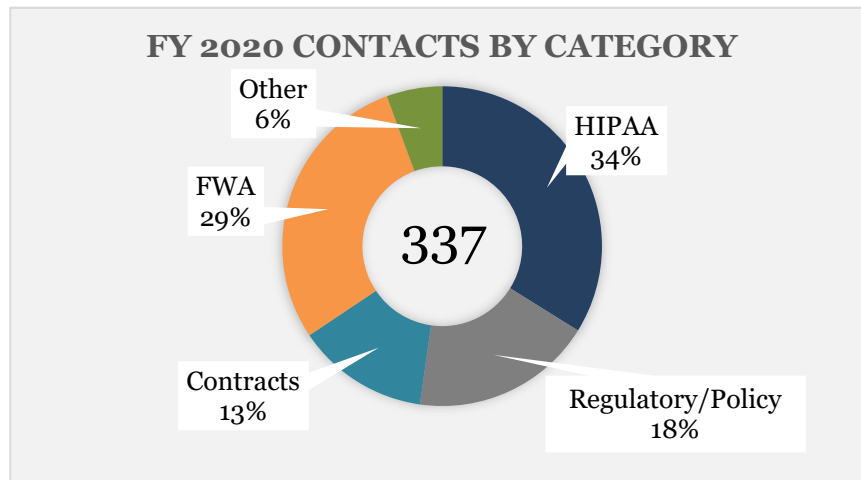
FY 2020 CountyCare Compliance Contact Volume

1. Total Volume of General Compliance Contacts

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



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



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

Categories	Count	Categories	Count
HIPAA - Privacy, Confidentiality and Security	114	Contracts/Agreements	45
Fraud, Waste, Abuse	100	Other	17
Regulatory/Policy	61		

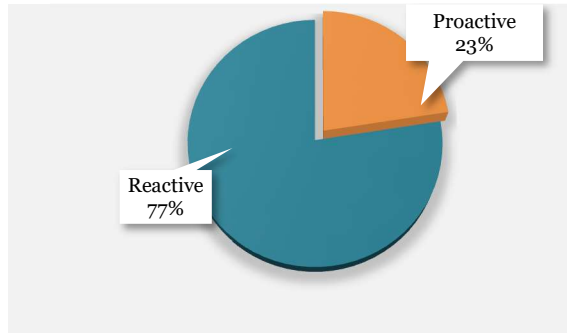
Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

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

3. FY 2020 Proactive vs. Reactive

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

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



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

4. Privacy, Confidentiality and Security (HIPAA)

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

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

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

The fourth breach involved an impermissible disclosure of five (5) CountyCare members' protected health information to a parent by a subcontractor's Care Coordinator. Compliance

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

notified the five (5) affected members, along with the Office for Civil Rights at the Department of Health and Human Services and HFS.

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

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

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

5. Fraud, Waste, Abuse, Mismanagement and Misconduct

A significant amount of time and effort are assigned to the prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct by CountyCare Compliance. Of the 337 CountyCare contacts in FY 2020, 30% or 100 contacts, were related to fraud, waste, abuse, mismanagement and misconduct. More information regarding the health plan's efforts related to these contacts can be found under Element 6 below, as the majority of these contacts were identified during or resulted in auditing, monitoring or investigation related activities.

Receiving and Responding to Communications from HFS OIG

CountyCare Compliance is also contractually obligated to have a system in place to receive and respond to various types of communications received from HFS OIG, received both on a regular basis (i.e., monthly), as well as on an ad hoc basis. Types of communications received from HFS OIG include several types of provider alerts, which impact the various types of providers used to provide benefits and services to CountyCare members, including Practitioners, (Medical, Dental and Vision), Pharmacies, Durable Medical Equipment (DME), Skilled Nursing Facilities (SNFs), Homemakers and Transportation providers.

Below is a summary of the volume of provider alerts, separated by notice type, received in FY 2020 from HFS OIG, which CountyCare Compliance then communicated to its relevant SIUs and benefit administrators, as appropriate:

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

FY 2020 Provider Alerts	
Active Investigation (also known as “Deconfliction”)	175
Payment Withhold	65
Payment Suspension Release	1
Disenrollment, Termination and Voluntary Withdrawal	300
Reinstatement	2
TOTAL	543

Additionally, HFS OIG communicates official data requests for information on an ad hoc basis, which generally require CountyCare Compliance to collaborate with its various SIU units, depending on the type of provider that is the focus of the request, to obtain and submit claims data, provider contracts, provider investigation or audit information, or communications made to a specific provider. During FY 2020, CountyCare received and responded to **51** requests for information submitted by HFS OIG.

Element 5

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

Enforcing Standards

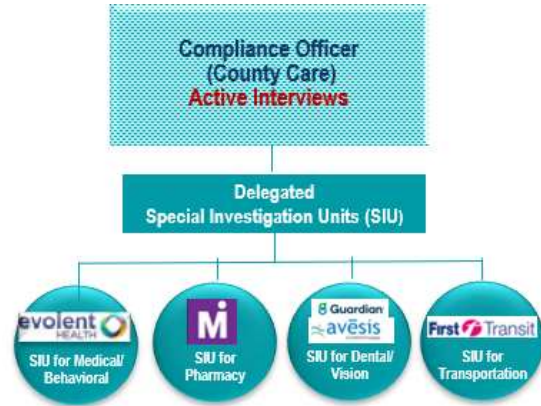
During FY 2020, CountyCare Compliance exercised and broadened the scope of its enforcement standards through:

- **Investigations and Guidance for Employee Related Corrective Actions.** CountyCare Compliance, via the Corporate Compliance department, investigated employee related complaints (for example, those related to confidentiality complaints or conflict of interest) and provided guidance to involved employees and leadership to remediate the situations and avoid repetition of the incident.
- **Monitoring Corrective Action Plans (CAPs), Deficiency Action Plan (DAPs), and Performance Improvement Plans (PIPs).** CountyCare Compliance, in collaboration with the CountyCare Delegated Vendor Oversight program, monitors any CountyCare vendor placed on a CAP, DAP or PIP for issues related to program integrity or compliance. During FY 2020, Corporate Compliance monitored four (4) vendors for improvement based on a CAP, DAP or PIP.
- **Privacy and Security (HIPAA) Breach Assessments.** CountyCare Compliance continues to work in collaboration with the CCH Privacy Officer to maintain consistency in

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

approach for breach assessments and to provide guidance to CountyCare workforce members and business associates.

- **Fraud, Waste, Abuse, Mismanagement and Misconduct Monitoring.** CountyCare Compliance collaborated closely with the Special Investigation Units of Delegated Vendors to identify potential fraud, waste, abuse, mismanagement and misconduct. CountyCare continues to work with its delegated SIUs to perform data analytics, including DRG auditing and coding analysis, in order to identify, investigate and report aberrant behaviors by providers, which includes processes for reaching out to providers to educate on issues identified as well as suggesting network termination for non-compliance with network provider agreement provisions, where appropriate.
- **Partnerships with Governmental Agencies.** CountyCare Compliance partnered with the HFS, HFS OIG, and Illinois' Medicaid Fraud Control Unit (MFCU).
- **Partnerships with non-Governmental Agencies.** CountyCare Compliance continues to collaborate with a number of organizations related to the detection of fraud and wrongdoing in the insurance industry. These non-governmental organizations include other managed health plans, the HealthCare Fraud Prevention Partnership (HFPP), National Insurance Crime Bureau (NICB), Midwest Anti-Fraud Insurance Association (MAIA), and the professional organization of compliance professionals, HCCA (Health Care Compliance Association).



Element 6

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

CountyCare Delegated Special Investigation Units

Prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct is a central responsibility for CountyCare Compliance. Benefit and Program Integrity is critical not only because it is a contractual requirement and a significant focus by the State and Federal government but because it is *the right thing to do*. The impetus of this key initiative is to ensure that federal, state, and county taxpayer dollars are spent appropriately on delivering quality, necessary care and preventing fraud, waste, abuse, mismanagement and misconduct in addition to protecting health plan members and providers.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

To identify potential fraud, waste, abuse, mismanagement and misconduct, CountyCare Compliance partners with each delegated vendor through their dedicated areas commonly known as Special Investigation Units (SIU).

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

Auditing and Monitoring Efforts for FY 2020

Fraud, Waste, Abuse, Mismanagement and Misconduct

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

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

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

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

S-FY 2020 Total	Tips ³	Referrals to HFS OIG ⁴	Overpayments Identified ⁵	Overpayments Collected ⁶
07/01 – 06/30/19	207	7	\$7,157,985.25	\$ 5,369,934.89

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

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

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

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

S-FY 2021 by Reporting Quarter	Tips	Referrals to HFS OIG	Overpayments Identified	Overpayments Collected
Q1 07/01 – 09/30/20	49	0	\$1,277,442.95	\$ 196,603.47
Q2 10/01 – 12/31/20	106	8	\$1,697,450.25	\$ 303,948.90

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

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

- Annual Compliance Attestation

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

- Grievances and Appeals Activities

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

Regulator Audit Activity for FY 2020

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

- HSAG 2020 Evaluation of Administrative Processes & Compliance

In September of 2020, CountyCare Compliance submitted a large volume of documentation to HSAG with respect to review topics addressing Fraud, Waste and Abuse (Standard XIII)

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

and Confidentiality (Standard IX). The onsite portion of the audit was conducted remotely by HSAG on November 12-13, 2020. HSAG recently communicated, via its final audit report, that CountyCare Compliance scored 100% with respect to each of the audit standards reviewed during the 2020 audit.

- HFS OIG Compliance Program Review Self-Assessment Questionnaire

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

Risk Assessment

The focus within CountyCare Compliance is prevention, detection and elimination of fraud, waste, abuse, mismanagement and misconduct, in addition to other areas of risk identified in FY 2020. Risk assessment currently is a fluid exercise within CountyCare Compliance, performed on a consistent, ongoing basis by monitoring issues that arise via the various lines of communications offered by the Department as well as in day-to-day communications with CountyCare health plan operations and benefit administrators.

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

Element 7

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

Identification of Systemic Issues

Sanction Screening Checks

- CCH maintains a policy and procedure paralleling the requirements set forth by the MCCN Agreement and the Department of Health and Human Services, Office of Inspector General, to ensure the screening of all contractors and workforce members.
- The goal of the policy is to avoid employing, engaging, contracting or agreeing with any individual or entity that is excluded or “sanctioned” from participation in a federal health care program or who is debarred from participation in federal procurement or non-procurement programs for the provision of goods or services.
- Sanction screening requirements continue to be embedded within each CountyCare contract and each CountyCare benefit administrator is required to screen each provider in their networks.

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

- Data is provided on a monthly basis to CountyCare Compliance to verify that sanction screening checks were conducted for medical and behavioral health providers. CountyCare vendors are also required to attest, on an annual basis, that sanction screening checks are performed in line with their contract requirements.

Prompt Reporting of Program Integrity Data to HFS OIG

CountyCare Compliance is contractually obligated to submit both monthly and quarterly reports to HFS OIG capturing its Program Integrity activities, particularly with respect to fraud, waste, abuse, mismanagement and misconduct identified that is related to providers/groups enrolled in the Illinois Medicaid program.

- Monthly Tips Report.
On a monthly basis, CountyCare Compliance submits a Tips Report to HFS OIG, documented within an Excel document, which lists out any allegations or incidents of suspected FWA that has been opened by the health plan related to a provider within that past month which impacts the HealthChoice Illinois program. Tips reported are not designed to be a fully vetted referral to HFS OIG; rather, they are designed to help provide necessary information to HFS OIG and avoid delays that would impact appropriate law enforcement or administrative review/action even before an audit or investigation has fully vetted the allegation.
- Quarterly FWA Report.
The MCCN Agreement also requires CountyCare Compliance to submit a quarterly fraud, waste and abuse report to HFS. This report, also known as the FWA Tool, must include all instances of suspected fraud, waste, abuse, mismanagement and misconduct, among other Program Integrity data requested, or indicate that there was no suspected fraud, waste, abuse, mismanagement and misconduct during that quarter. While the FWA Tool is not intended to include administrative billing issues or routine claim errors, a considerable amount of time has been spend clarifying with HFS OIG the types of Program Integrity related information that should be included within the report.

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

Cook County Health
CountyCare Compliance Program
FY 2020 ANNUAL REPORT

VI. Looking Ahead to 2021

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

These priorities have been established for the CountyCare Compliance Program:

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