ANNUAL REPORT

Fiscal Year 2023

Prepared By:

Cook County Health
CountyCare Compliance Program

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I. Introduction

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

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

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

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

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

II. CountyCare Compliance Program – Infrastructure and Scope

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

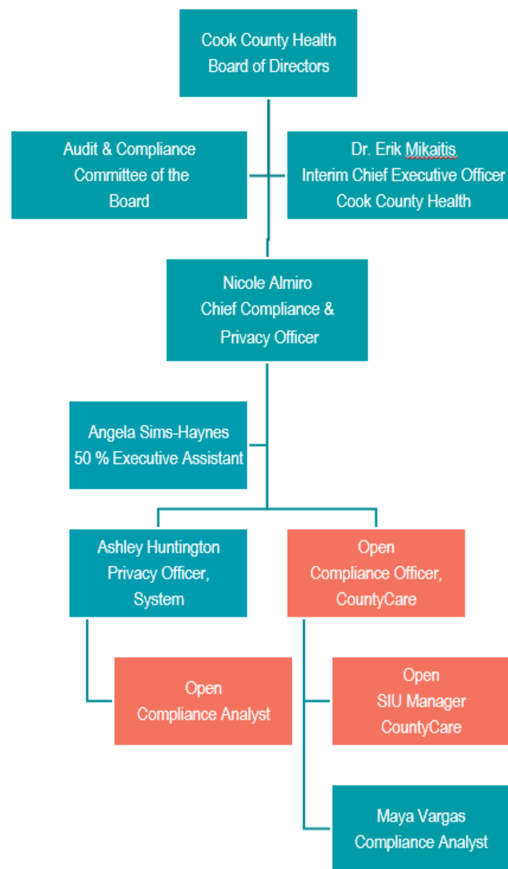
CountyCare Compliance Program Infrastructure

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

The current Compliance Departmental Organization Chart for CountyCare appears below.

[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.

Organization Chart



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

CountyCare Compliance Program Scope

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

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

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

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

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

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

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

III. Annual Compliance Program Activity – Performance of the Elements

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

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

Element 1:

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

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

COOK COUNTY HEALTH

CODE OF ETHICS

The Cook County Health System's Code of Ethics outlines our expectations of everyone within Cook County Health (CCH), whether you are a part of the health and hospitals side of the system or part of the insurance plan. This applies to all CCH personnel, whether you are employed by the CCH or if you represent CCH in any way, this includes, but is not limited to, volunteers, independent contractors, consultants and other business partners (vendors) who are not employees but are working at CCH ("Personnel").

We will conduct ALL our interactions respectfully, responsibly, honestly, professionally, and in compliance with laws, regulations, and policies of the organization.

All Personnel are expected to uphold honest and ethical behavior, comply with laws, regulations, and system policies, and to fulfill their responsibilities as important members of the CCH organization. CCH management also has a duty to conduct business with integrity, to act responsibly and to be accountable for their decisions and actions made on behalf of CCH. Management is also expected to provide an environment where Personnel can feel comfortable raising concerns and reporting actual or potential instances of wrongdoing without the fear of retaliation.

Compliance with the Code of Ethics is required.

Failure to comply with the standards established and outlined by this Code of Ethics or to cooperate with CCH leadership regarding activities related to this Code may subject individuals to disciplinary action up to and including discharge of employment or termination of the written contract. Personnel who violate certain principles outlined in this Code may also be subject to fines and penalties imposed by the county, state and Federal government.

CCH's Corporate Compliance is responsible for the final interpretation of this Code and will decide necessity for reviews and revisions.

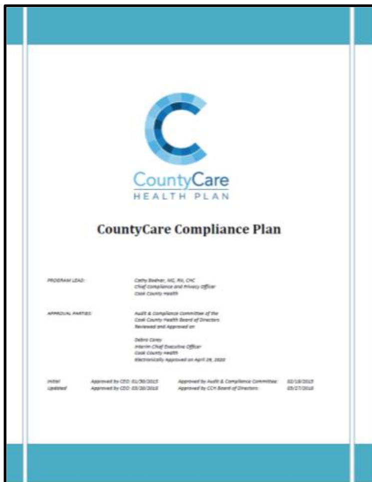
This Code outlines the culture and principles that are expected from EVERYONE.

A. **QUALITY OF CARE**
We will,
- Treat each patient and plan member with dignity, courtesy and respect. We make no distinction in the availability of services; the admission, transfer or discharge of patients; or in the care we provide based on age, gender, disability, race, color, religion, national origin, or any other characteristic protected by law.
- Provide a safe environment staffed by skilled and compassionate health care professionals who uphold standards of professional practice throughout all our facilities and programs.
- Promote the delivery of the highest quality of care that is both necessary and appropriate, within our capabilities and capacity, to patients and health plan members.
- Communicate through teamwork and collaboration to promote quality care and patient safety.
- Protect the privacy of our patients and health plan members by complying with all federal and state laws, organizational policies.
- Commit to timely, thorough, and accurate medical record documentation that supports the quality care provided to our patients and plan members.
- As a provider of care, we will follow the requirements of the Emergency Medical Treatment and Labor Act, also known as EMTALA, by providing for an appropriate medical screening examination to determine whether or not an individual requesting such examination has an emergency medical condition and if the patient is determined to have an emergency medical condition, the patient will receive treatment within CCH capabilities and capacity until the condition is stabilized or an appropriate transfer to another facility can be made. CCH will accept an appropriate transfer of a patient who requires its specialized capabilities or facilities if CCH has the capacity to treat the patient.
- Comply with all laws, regulations and organization policies required to promote workplace safety. These policies are in place to protect patients, visitors, and personnel.

B. **RESEARCH**
We will,
- Carry out research involving, human subjects in an ethical manner with the utmost integrity in accordance with federal regulations and organizational policies and procedures.
- Obtain approval for all research activities in advance by the Institutional Review Board of Cook County Health and by CCH leadership.

Code of Ethics

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



Compliance Plan

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

Policies, Procedures and Contract Requirements

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

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

Ad Hoc Activities/Guidance

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

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

Examples of areas assessed:

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

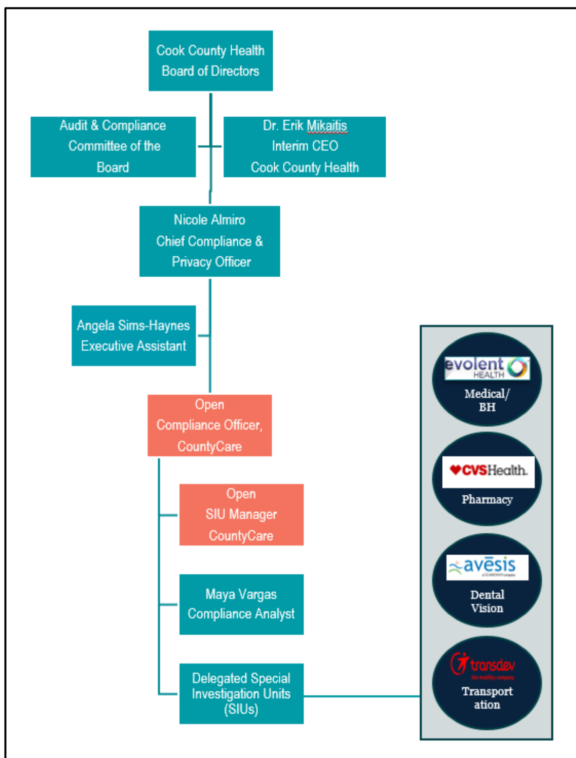
- Recipient Restriction (Lock In) Program ("RRP"). CountyCare Compliance continued to provide guidance and reviewed review revisions to policies and procedures addressing RRP processes, including how members are enrolled in the Proactive and Reactive Lock-In Programs, communications made to members/providers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

Element 2

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

Compliance Office and Oversight Committees

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



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

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

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

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

- **Audit & Compliance Committee (ACC) of the Board** advises the CCH Board of Directors regarding the implementation of standards and processes to assure professional responsibility and honest behavior, compliance with regulatory requirements, and risk management. The ACC of the Board receives periodic updates regarding the CountyCare Compliance program, including metrics related to program activities and FWA.

- **Regulatory Compliance Committee**, chaired by the Compliance Officer, CountyCare, provides oversight of and guidance to CountyCare operations to ensure regulatory compliance and fulfill Compliance Program requirements, which include the implementation and operation of the Compliance Program. The Regulatory Compliance Committee also reviews CountyCare activity pursuant to Compliance Program requirements and contractual requirements, including, but not limited to audits, monitoring activity, and corrective action plans. The Regulatory Compliance Committee reports through the Chief Compliance and Privacy Officer to the ACC of the Board.

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

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

- **Program Integrity / FWA Meetings,** comprised of delegated vendors occurring on a bi-weekly or monthly cadence, depending on the vendor and amount of activity. Led by the CountyCare Compliance team, the meetings provide an overview of the vendors' activities and serve as a forum to review, approve, modify, or reject the direction of audits, investigations, data mining efforts, and recoupment activity; and

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

Element 3

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

Education and Training

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

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

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

Element 4

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

Receiving and Responding to CountyCare-Related Complaints

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

CountyCare Compliance Email	CCH Corporate Compliance Hotline	CountyCare FWA / Compliance Hotline (staffed by Evolent)	CCH Online Reporting Portal	CCH Open Door Reporting Policies
countycarecompliance@cookcountyhhs.org	1-866-489-4949	1-844-509-4669	www.cchhs.ethicspoint.com	

All lines of communication are monitored in real time by CountyCare or Corporate Compliance staff, except the FWA/Compliance Hotline which is managed by Evolent (Third Party Administrator (TPA) for CountyCare). CountyCare Compliance meets with the Evolent team biweekly to discuss issues received through the hotline and appropriate responses to those issues, with urgent issues escalated via email. Where possible, reporters are allowed to remain anonymous via the hotline and reporting portal options.

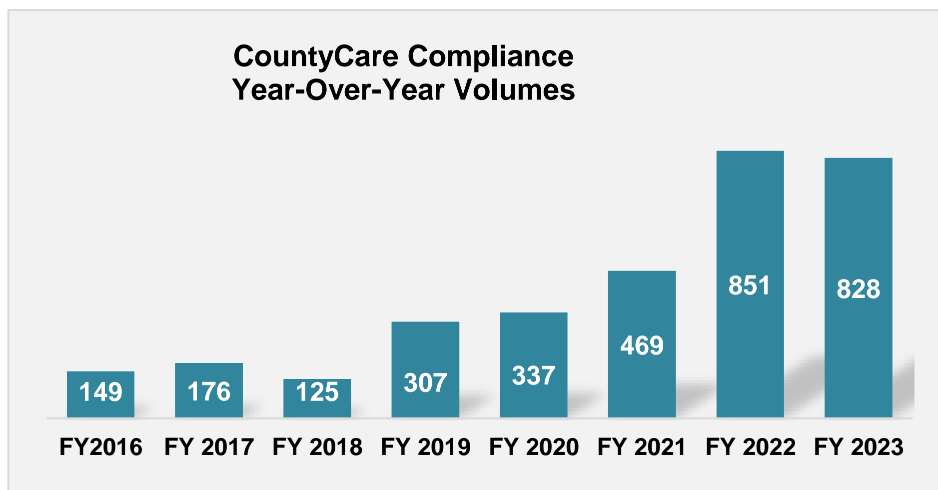
The CountyCare Compliance team followed established CountyCare Compliance processes for responding to issues and complaints received during the year. CountyCare Compliance tracks and identifies trends and patterns within its contacts and activities to further mitigate organizational risks and facilitate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

Below are summary activity metrics from CFY 2023.

CFY 2023 CountyCare Compliance Contact Volume

1. <u>Total Volume of General Compliance Contacts</u>

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

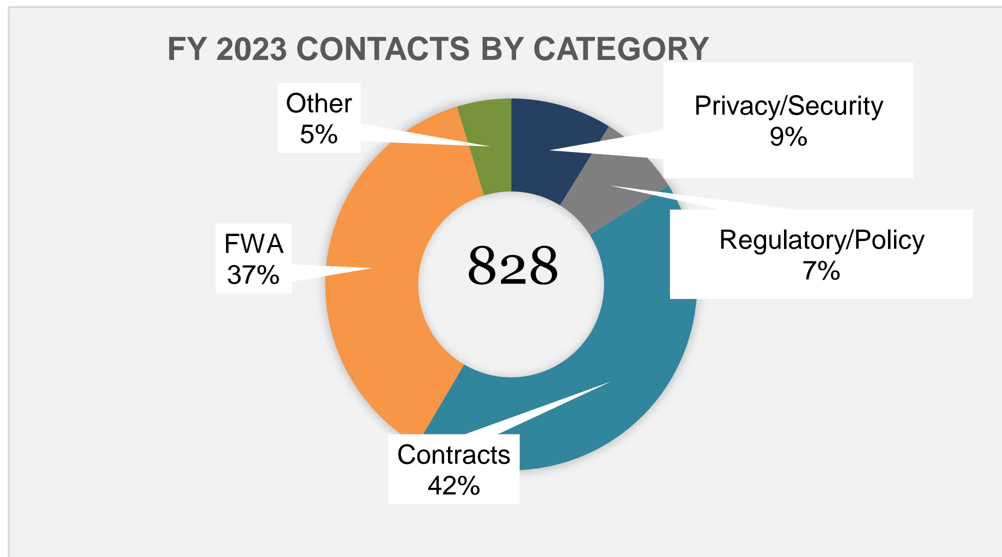


2. <u>Inquiry/Issue Breakdown by Category CFY 2023 (December 1, 2022-November 30, 2023)</u>

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

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

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



The associated category count follows:

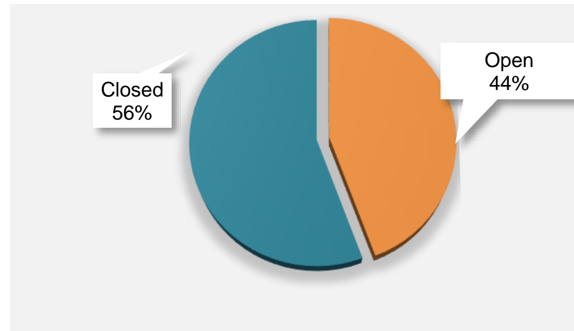
Categories	Count
Contracts/ Agreements	351
Fraud, Waste, Abuse	305
Privacy, Confidentiality and Security (HIPAA)	73
Regulatory/Policy	60
Other	39
Total	**828**

Issue types included in the "Other" category include queries regarding:

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

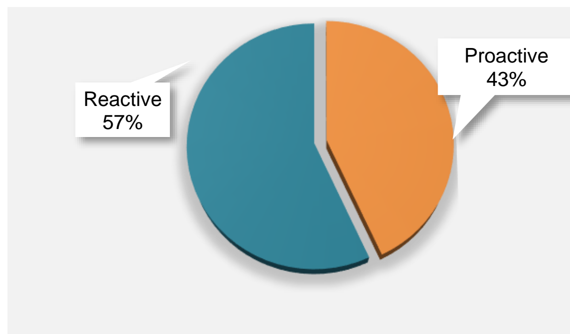
3. CFY 2023 Contact Status

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



4. CFY 2023 Proactive vs. Reactive

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



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

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

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

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

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

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

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

6. <u>Fraud, Waste, and Abuse, Mismanagement and Misconduct (collectively, "FWA")</u>

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

Receiving and Responding to Communications from HFS OIG

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

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

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

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

Element 5

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

Enforcing Standards

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

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

- Monitoring Corrective Action Plans ("CAPs"), Deficiency Action Plans ("DAPs"), and Performance Improvement Plans ("PIPs"). CountyCare Compliance, in collaboration with the CountyCare Delegated Vendor Oversight program, monitors any CountyCare vendor placed on a CAP, DAP, or PIP for issues related to program integrity or compliance. During CFY 2023, no vendors were placed on a compliance or program related integrity-related CAP, DAP, or PIP.

- Privacy and Security ("HIPAA") Breach Assessments. CountyCare Compliance, in collaboration with the Privacy Officer, maintains consistency in approach for breach assessments and provide provides guidance to CountyCare workforce members and business associates.

- Fraud, Waste, Abuse, Mismanagement and Misconduct (collectively, "FWA") Monitoring. CountyCare Compliance collaborated closely with delegated Special Investigation Units ("SIUs") to identify and mitigate potential FWA. This includes following processes for provider education, recovery of identified overpayments from providers, and network termination for non-compliance with network provider agreement provisions, where appropriate.

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

Element 6

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

CountyCare Delegated Special Investigation Units

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

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

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

Auditing and Monitoring Efforts for SFY 2023

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

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

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

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

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

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

FWA Recovery Metrics (SFY 2023 – Q1 SFY 2024)

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

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

[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 monthly are not fully vetted referrals, only preliminary information that SIUs are providing to HFS OIG in real time. Additionally, not all investigative activity is reported to HFS OIG via the Tips report (for example, data mining efforts or audits based on proprietary algorithms are not reported.)

[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.

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

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

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

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

Annual Compliance Audit and Attestation

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

Grievances and Appeals Activities

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

Regulator Audit Activity for CFY 2023

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

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

Risk Assessment

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

Element 7

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

Identification of Systemic Issues

Sanction Screening Checks

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

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

Prompt Reporting of Program Integrity Data to HFS OIG

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

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

Prompt Responses to HFS OIG Data Requests / Request for Information

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

There are typically two types of requests:

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

Requests for Audit (RFA)

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

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

IV. Looking Ahead to CFY 2024

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

These priorities have been established for the CountyCare Compliance Program:

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

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