ANNUAL REPORT

Fiscal Year 2024

CountyCare

A MEDICAID HEALTH PLAN

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. The mission statement was 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.

For over a decade, CCH developed and implemented the CountyCare Compliance Program in order to adhere to the Medicaid Managed Care Program Integrity requirements outlined by both the 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") 2024 CountyCare Compliance Program Annual Report summarizes compliance activities addressed in CFY 2024 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.

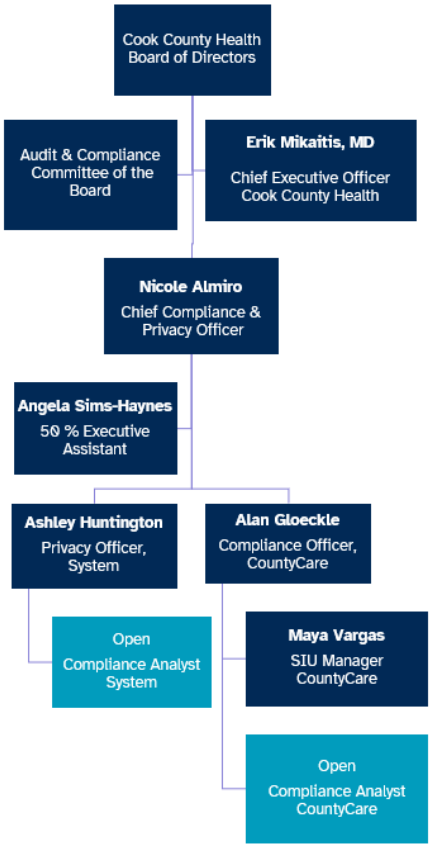
CountyCare Compliance Program Infrastructure

During CFY 2024, the Compliance Officer, CountyCare position remained largely open until August 2024 when Alan Gloeckle joined as Compliance Officer, CountyCare. Prior to August, the majority of CountyCare related compliance issues were handled by the Chief Compliance & Privacy Officer, CountyCare SIU Manager, 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



Filling the CountyCare Analyst position will continue to be a priority in CFY 2025. Additionally, four positions remain open currently within the CCH Corporate Compliance office and efforts to fill the open positions are a critical priority for CFY 2025.

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 on core elements of the Compliance Program, including those activities mandated by the MCCN Agreement and required by HFS and HFS OIG.

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. It is designed to accommodate future changes in regulations and laws and will be updated to address issues not currently covered, issues related to new service offerings, and regulatory requirements.

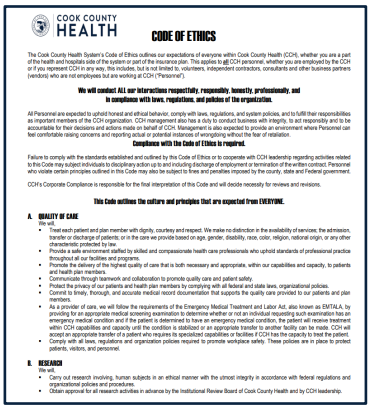
III. Annual Compliance Program Activity – Performance of the Elements

Below is a summary of the activities performed by CountyCare Compliance in CFY 2024 which also serves to demonstrate the effectiveness of the program, organized by the seven Compliance Program Elements for a comprehensive compliance program.[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 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.

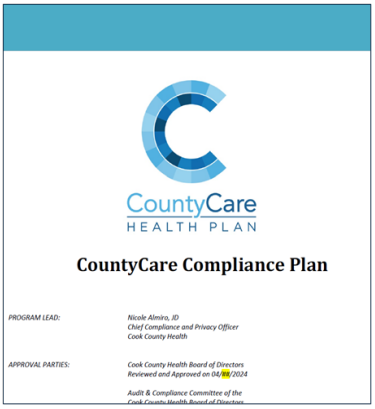
B. RESEARCH

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.



CountyCare HEALTH PLAN

CountyCare Compliance Plan

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

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

Audit & Compliance Committee of the
Cook County Health Board of Directors

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 2024, 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:

- Non-Emergency Transportation (NEMT) Benefit Services Vendor Contracting and Implementation. CountyCare Compliance reviewed and provided guidance throughout contracting, pre-delegation audit and process implementation stages of bringing a new NEMT vendor on board with CountyCare, specifically related to requirements addressing corporate compliance, ethics, training, FWA investigations/audits, and the privacy of member protected health information.
- Recovery of Fee for Service (FFS) Overpayments. In mid-2024, HFS OIG required all Managed Care Organizations to establish processes for recovering funds from providers in network that have outstanding fee-for-service (FFS) debts with HFS and / or HFS OIG. CountyCare Compliance reviewed and provided guidance to operations related to the development and implementation of the corresponding process, which requires the health plan to recover funds via the offset of adjudicated claims and return any recovered funds directly to HFS OIG.
- FWA Identified Related to COVID-19 Testing. CountyCare Compliance continued to monitor, review and provide 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. CountyCare Compliance continued to be a voting 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 potential new vendor partners, including for telehealth services, housing / member support services and HEDIS quality vendor services.
- Risk Adjustment. CountyCare Compliance reviewed federal and state Medicaid requirements related to Risk Adjustment and provided guidance to CountyCare provider relations and finance operational areas related to ongoing Risk Adjustment activities.
- Freedom of Information Requests from HFS. CountyCare Compliance, in collaboration with the CCH Office of General Counsel, reviewed federal, state and HFS contract requirements related to receipt of, review and responses to Freedom of Information (FOIA) requests addressing health plan operations and provided guidance on operational processes for reviewing and handling FOIA requests.
- FWA Checks for New Provider Network Contracts. Provider Contracting and CountyCare Compliance continued to partner to ensure that FWA and sanction screening checks are performed for all potential CountyCare Network Providers. During 2024, new provider contracting software was implemented and integrated into the overall process, which required further adjustments and process level changes. Due to the significant volume of FWA and sanction screening requests, efforts are ongoing to identify options to streamline FWA check processes for efficiency.

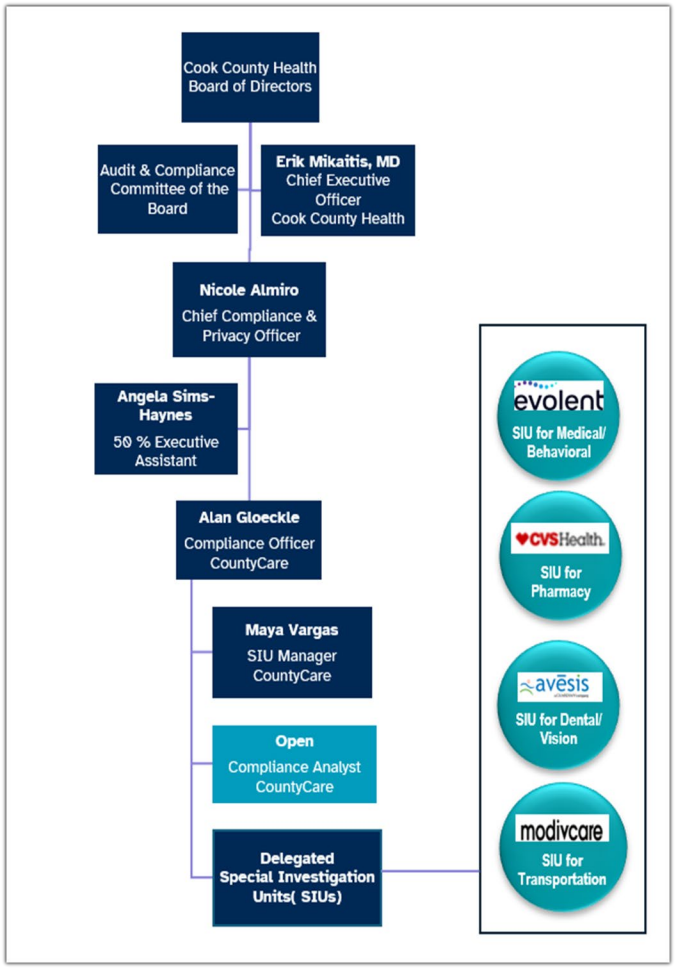
- Annual Vendor Audit Protocol Enhancement. CountyCare Compliance continued to partner closely with the Delegated Vendor Oversight team during their operational audits, including the review and update of Compliance vendor audit protocols to incorporate emerging compliance related risk areas and new Medicaid requirements. Annual audits of vendors included verification that Cultural Competency and Critical Incident trainings were delivered per health plan contract requirements.
- Excluded Prescriber Review and Reporting. CountyCare Compliance, in collaboration with the plan Pharmacy Benefit Manager (PBM), implemented a process to review monthly reporting delivered by the PBM that identifies excluded prescribers that may be in the CountyCare provider network and further communicate this information operationally to ensure that payments are not made to excluded providers.
- Recipient Restriction (Lock In) Program ("RRP"). CountyCare Compliance continued to provide guidance and reviewed revisions to policies and procedures addressing RRP processes, including how members are enrolled in the Proactive and Reactive Lock-In Programs, communications made to members/providers regarding lock-in changes, and the process for reporting RRP program operations to HFS OIG.

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 filled in late August 2024. Prior to this, the Chief Compliance & Privacy Officer assumed primary operational responsibility for CountyCare Compliance, with the assistance of the CountyCare Special Investigation Unit (SIU) Manager. The primary duties of the Compliance Officer, CountyCare did not change during CFY 2024.

The two committees tasked with oversight over the CountyCare Compliance Program met quarterly in CFY 2024, 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 ethical 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 2024, 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.

- **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.

- **One-On-One Meetings with HFS OIG**, at the request of HFS OIG, CountyCare Compliance and HFS OIG met twice during 2024 to review FWA operations and portal data, establish reporting expectations, and discuss current issues and concerns.

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.

CountyCare Compliance participated 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 SIU Manager.

In September, CountyCare Compliance provided a lunch and learn session on conflict of interests, gift restrictions, and dual employment survey reporting requirements. Cook County Ethics Ordinance post-employment restrictions were also discussed, along with practical guidance on how these restrictions interact with the Request for Proposal process.

CountyCare Compliance also highlighted the importance of privacy reminders and education and to that end, offered a Lunch and Learn session for all CountyCare staff in December. This training featured current trends in privacy risks, as well as walking through real examples of privacy incidents at CCH. Staff were able to present their fact-based scenarios and questions at the end of the session, and received post-session job aides on recalling emails in the event sensitive information is inadvertently sent to an incorrect recipient.

With the renewal of the SmartSheet contract, which is used as a project management tool, CountyCare leadership requested privacy reminders to staff on appropriate use of the tool. CountyCare Compliance drafted an email blast to all SmartSheet users on safeguards to undertake while using the tool, as well as reminders to periodically check authorized users and to avoid inputting protected health information into the tool.

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 2024 as follows:

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

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.

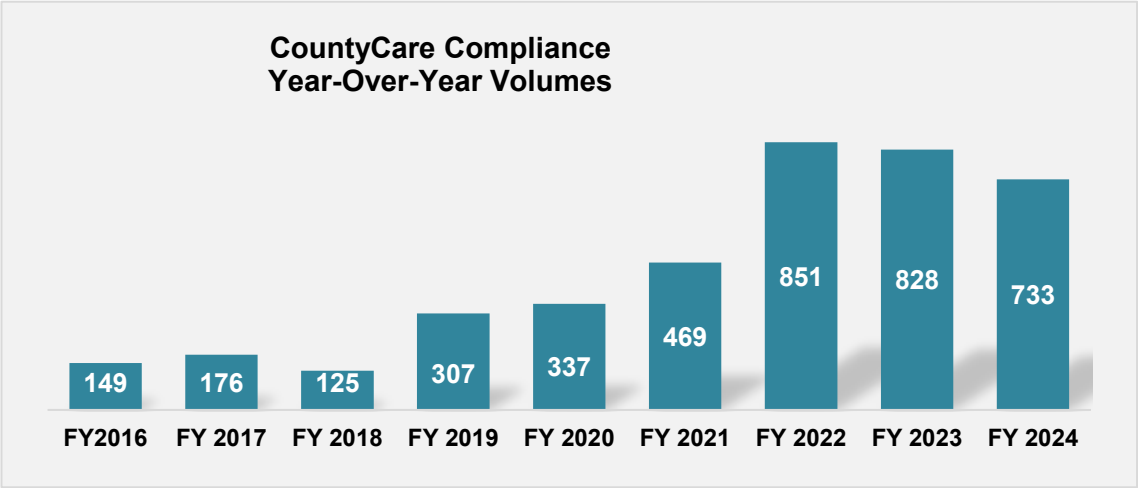
The CountyCare Compliance team followed established CountyCare Compliance processes for responding to issues and complaints received during the year. CountyCare Compliance tracks and identifies trends and patterns within its contacts and activities to further mitigate organizational risks and facilitate 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 2024.

CFY 2024 CountyCare Compliance Contact Volume

1. Total Volume of General Compliance Contacts

   733 contacts were documented for the CountyCare Compliance Program during CFY 2024. The chart that follows illustrates the year-over-year activity, which shows that program activity remained fairly consistent, with only a 11% decrease in activity volume compared to the previous fiscal year. Decreased activity can largely be attributed to efforts to onboard and train new compliance staff and significant time spent compiling responses to external regulator audits.



2. Inquiry/Issue Breakdown by Category CFY 2024 (December 1, 2023-November 30, 2024)

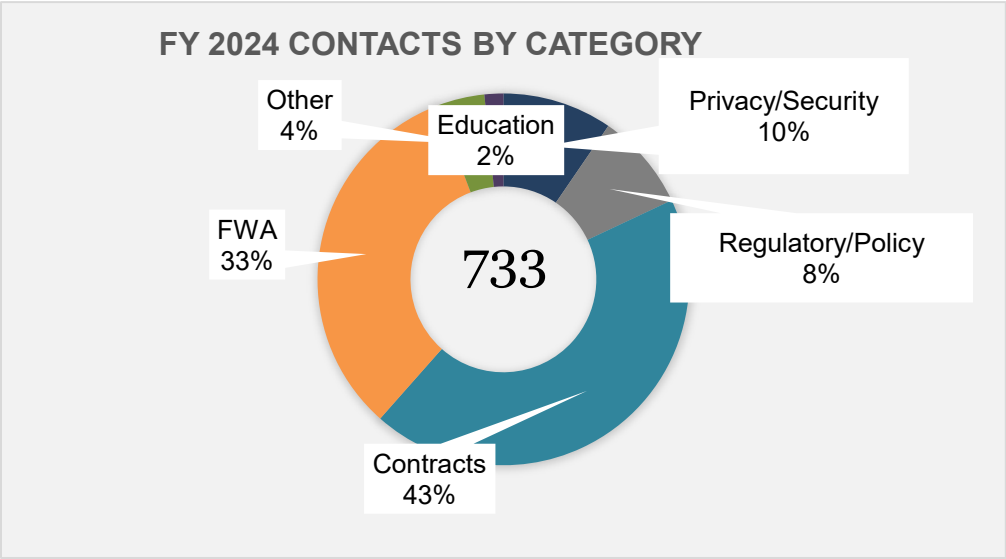
Categories have been defined to allow CountyCare Compliance to accurately organize and report compliance inquiries/issues received. The CFY 2024 CountyCare Compliance issues addressed fall within the following categories:

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

Education

- Other

The chart below illustrates the volume of contacts received by CountyCare Compliance in CFY 2024, separated by issue category.



The associated category count follows:

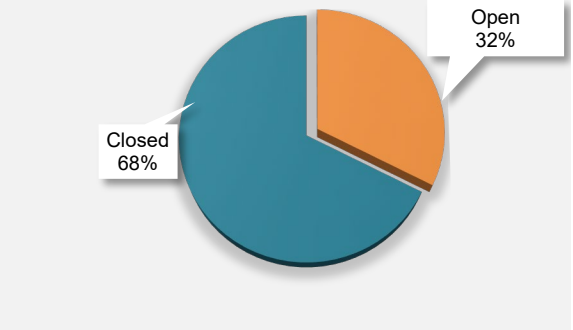
Categories	Count
Contracts/ Agreements	319
Fraud, Waste, Abuse	240
Privacy, Confidentiality and Security (HIPAA)	70
Regulatory/Policy	62
Education	12
Other	30
Total	**733**

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

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

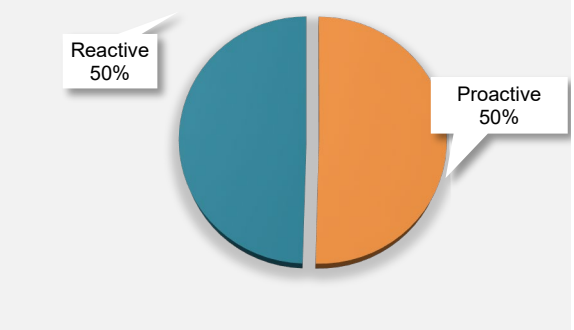
3. CFY 2024 Contact Status

Of the 733 contacts reported throughout CFY 2024, 495 contacts were resolved at the end of the fiscal year. The remaining 238 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 2024 Proactive vs. Reactive

Of the 733 CountyCare contacts received in CFY 2024, 50% (370) contacts were proactive while 50% (363) 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 2023.



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 2024, this category accounted for roughly 9.5% (70 issues) of all CountyCare compliance activities.

During the year, 29 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. As with prior years, the majority of the incidents involved mistakes by CountyCare delegated vendors 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 such that CountyCare Compliance considered these incidents to be sufficiently mitigated. This was a slight increase of two additional HIPAA incidents in CFY2024 compared to the 27 incidents reported in CFY2023.

CountyCare Compliance confirmed one (1) HIPAA breach for CFY2024. This breach was experienced by a vendor, Medical Home Network (MHN), when a phishing attack affected two (2) employees' emails. Through a lengthy investigation, including working with MHN's legal counsel and cybersecurity experts, CountyCare Compliance confirmed that 681 members were affected by this breach. All breach notification requirements were completed, including sending notification letters to those affected, posting about the breach on the CountyCare website, and notifying the appropriate regulators. MHN reported to CountyCare Compliance that the Office for Civil Rights (OCR) accepted MHN's breach report and closed the case, as sufficient information was provided to show that the incident had been addressed and controls put in place to prevent a similar occurrence in the future.

Beyond the above, 37 contacts within the HIPAA category reflected guidance or review activities provided by CountyCare Compliance and/or the CCH Privacy Officer on topics including 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.

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

   A significant amount of time and effort is assigned to the prevention, detection and elimination of FWA by CountyCare Compliance. Of the 733 CountyCare contacts in CFY 2024, 33% or 240 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 2024 from HFS OIG, which CountyCare Compliance then communicated to its relevant SIUs and benefits administrators, as appropriate. The volume of Provider Alerts decreased in CFY 2024 to 143, from 211 in the year prior, which also impacts the drop in FWA activities noted in the section above.

Provider Alert Type	CFY 2023	CFY 2024
Active Investigation (also known as "Deconfliction")	8	6
Payment Withhold	16	27
Payment Suspension Release	8	5
Disenrollment, Termination, and Voluntary Withdrawal	171	93
Reinstatement	8	123
TOTAL	**211**	**143**

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 2024, 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 2024, CountyCare Compliance placed one vendor on two separate compliance / program integrity related DAPs that focused on vendor contract management and payments for genetic testing services that require prior authorization.

- Privacy and Security ("HIPAA") Breach Assessments. CountyCare Compliance, in collaboration with the Privacy Officer, maintains consistency in approach for breach assessments and 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 the 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"), 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, specifically the SIU Manager, provides direct oversight of program integrity activity.

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 2024

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 catalog 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.

During SFY 2024, there was a continued focus on potential 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 and completed of the providers submitting the claims. Review and investigation by CountyCare SIU of flagged providers included onsite visits, record reviews, and interviews with lab staff (where appropriate).

Collectively, a total of $5,090,061 was recovered in overpayments in SFY 2024, which is slightly less than the $6,968,261 collected in overpayments in SFY 2023. This slight decrease in overpayments recovered is largely due to vendor transitions for both the pharmacy benefit manager (PBM) FWA and non-emergency transportation (NEMT) FWA SIU teams during the last year, as well as a focused effort to identify and investigate potential FWA related to covid testing, both of which caused case activity and active recoveries to drop.

All FWA and Payment 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. At the start of SFY 2024 (i.e., July 1, 2023), CountyCare Compliance began separately tracking recovery metrics for FWA SIU activities and Payment Integrity activities, as outlined below.

FWA Activity Metrics

FWA activities capture results from investigations and audits of in and out of network providers that are conducted by CountyCare's SIU partners and are focused on allegations of potential FWA, as defined by HFS OIG.

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. Tips are reported to HFS OIG in real time upon receipt by the SIU and are not fully vetted referrals, only preliminary information that SIUs have received. Where CountyCare Compliance identifies actual instances of FWA, mismanagement, or misconduct, information regarding the investigation is *referred* to HFS OIG via the Reporting Portal.

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

FWA metrics for both SFY 2024 along the first quarter of SFY 2025, as reported to HFS OIG via the FWA Portal, follow:

FWA Recovery Metrics (SFY 2024 – Q1 SFY 2025)

S-FY	Reporting Period	Tips	Referrals to HFS OIG	Overpayments Identified	Overpayments Collected
2024	**Q1** 7/01 -09/30/23	68	48	$638,851	$166,269
2024	**Q2** 10/01 – 12/31/23	43	17	$4,921,898	$193,579
2024	**Q3** 1/01 – 03/31/24	33	16	$759,327	$15,644
2024	**Q4** 4/01 – 06/30/24	33	14	$6,223,156	$253,352
	Total SFY 2024	**177**	**95**	**$12,543,232**	**$629,035**
2025	**Q1** 7/01 – 09/30/24	36	25	$9,163,789	$42,243

CountyCare Compliance continuously monitors the process to ensure appropriate action is taken, including reporting suspected FWA to HFS OIG. In SFY 2024, CountyCare referred 95 cases to the HFS OIG for possible FWA, which is larger than the 74 cases referred during SFY 2023. This increase in case activity demonstrates the health plan's continuing efforts for increased oversight of CountyCare providers and is also the outcome of focused investigation efforts related to COVID-19 testing claims submitted by lab providers.

Payment Integrity Activity Metrics

Payment Integrity activities capture results from data mining and clinical audit recoveries that are carried out by CountyCare's vendor partners from an operational level. Recoveries for these activities are identified at the claim line level and are not considered FWA – related, which means they are not reported to HFS OIG via the mandated reporting requirements. CountyCare Compliance has oversight over the data mining and clinical audit activities conducted by our vendor partners and actively approves new concepts for data mining and audits, receives reporting and monitors recovery amounts. Reports are regularly reviewed for outlier provider activity that may need to be referred to the SIUs for additional FWA investigation.

Payment Integrity Audit metrics for both SFY 2024 along the first quarter of SFY 2025 are below:

Payment Integrity Recovery Metrics (SFY 2024 – Q1 SFY 2025)

S-FY	Reporting Period	Overpayments Identified[3]	Overpayments Collected[4]
2024	**Q1** 7/01 -09/30/23	$587,200	$670,290

[3] *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 on the audit or review conducted. 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.

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

S-FY	Reporting Period	Overpayments Identified[3]	Overpayments Collected[4]
2024	**Q2** 10/01 – 12/31/23	$655,337	$174,479
2024	**Q3** 1/01 – 03/31/24	$2,705,060	$3,042,717
2024	**Q4** 4/01 – 06/30/24	$620,727	$573,543
	Total SFY 2024	**$4,568,324**	**$4,461,029**
2025	**Q1** 7/01 – 09/30/24	$892,434	$994,640

Proactive Preventative Loss Metrics

Additionally, CountyCare Compliance continued to build on efforts to identify and track dollars that were saved through proactive preventative loss efforts, meaning that potential FWA issues and/or mistakes with claims were proactively identified prior to the payment being made to a provider. For SFY 2024, CountyCare Compliance and SIU vendor partners were able to prevent approximately $2.08 million in losses, an increase from the $1.67 million previously saved in SFY 2023.

Metrics related to proactive preventative loss for SFY 2024 and the first quarter of SFY 2025 are included below:

Proactive Preventative Loss Metrics (SFY 2024 – Q1 SFY 2025)

S-FY	Reporting Period	Overpayments Avoided
2024	**Q1** 07/01 -09/30/23	$30,490
2024	**Q2** 10/01 – 12/31/23	$145,463
2024	**Q3** 01/01 – 03/31/24	$378,316
2024	**Q4** 04/01 – 06/30/24	$1,523,076
	Total SFY 2024	**$2,077,345**
2025	**Q1** 07/01 – 09/30/24	$4,670,092

Annual Compliance Vendor Audits and Vendor Annual Attestation Statement

CountyCare Compliance continued to utilize an Annual Compliance Attestation, issued to all CountyCare's delegated vendors in June 2024. The Compliance Attestation required all vendors to attest to several compliance provisions in their contracts, including compliance with the requirements of Section 9.2 of the MCCN.

Additionally, each of CountyCare's delegated vendors completed a compliance audit during CFY 2024, which was facilitated through a partnership with the Delegated Vendor Oversight audit

process. Any issues identified during the audit were tracked until full remediation was completed by the vendors.

Credit Balance Audits

CountyCare Compliance, in conjunction with CountyCare Finance and Provider Relations, reviewed and approved a new credit balance audit process that was implemented for CountyCare network providers in CFY 2024 by the Evolent Payment Integrity team and their sub vendor. Audits are currently in various stages for multiple providers / facilities. Monitoring discussions and reporting is provided during monthly meetings.

System Access Tracker Reviews

CountyCare Compliance continued to conduct biannual monitoring reviews 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").

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 2024

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. No significant findings were communicated during the onsite report with respect to either of the audit standards reviewed. The final audit report was issued by HSAG in May of 2024. CountyCare scored 100% on both compliance related elements - Fraud, Waste and Abuse (Standard XIII) and Confidentiality (Standard IX).

Additionally, CountyCare was engaged by the Centers for Medicare and Medicaid Services (CMS), via their external Unified Program Integrity Contractor (UPIC) auditor (CoventBridge), for a Managed Care Plan Audit in July of 2024. The audit covers multiple operational areas, including Compliance and FWA efforts. CountyCare Compliance submitted comprehensive documentation in response to a compliance specific document request issued by CoventBridge in early September 2024. Feedback from the UPIC auditor has not yet been received. The audit is expected to extend into CFY 2025.

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. CountyCare Compliance is now using HFS OIG's FWA reporting portal, which is designed to receive case updates in real-time. This portal replaces the previous requirement for monthly and quarterly report submissions.

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 2024, 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 software 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), frequently 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:

Requests for Information (RFI)

These requests 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 2024, CountyCare received and responded to 9 requests for information submitted by HFS OIG, HFS, or other government agencies. This is a significant decrease from the number of requests received in CFY 2023, which was 42 requests.

IV. Looking Ahead to CFY 2025

In CFY 2025, CCH Compliance will increase focus on contract adherence and compliance best practices. Focus will be sharpened by an increased auditing and monitoring effort through establishment of a workplan based on a completed risk assessment. 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.

These priorities have been established for the CountyCare Compliance Program:

- Initiate a formal, unique to CountyCare, risk assessment process with executive leadership and key thought leaders to identify outstanding risks and challenges to meet the standards of an effective health plan compliance program.

- Develop and implement a formal CountyCare Compliance Auditing and Monitoring Workplan, to outline how CountyCare Compliance audits and/or monitors identified compliance risk areas.
- 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 transparency and compliance throughout the Health Plan. In furtherance of these opportunities, specific areas for educational focus will include the CCH Code of Ethics and the Cook County Ethic Ordinance.
- Review the vendor Request for Proposal (RFP) and contracting process for opportunities to increase guidance on County ethics requirements as well as identify areas for increased compliance efficiencies.
- Review the revised HFS MCCN contract language related to Program Integrity, update the internal CountyCare FWA Plan and relevant FWA policies and procedures, educate delegated SIU units on requirement changes, and request revisions to delegated SIU policies and procedures, as needed.
- Update Compliance audit protocols for CountyCare Delegated Vendor Oversight program audits and Annual Vendor Certification based on the revisions to the HFS MCCN contract Program Integrity requirements.
- Continue to prepare for and generate responsive information in relation to the compliance items within the UPIC Managed Care Plan Audit.