Minutes of the Meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System (CCHHS) held Friday, June 19, 2020 at the hour of 10:00 A.M. This meeting was held by remote means only, in compliance with the Governor's Executive Orders 2020-7 and 2020-39, and the Governor's Disaster Proclamation issued on May 29, 2020.

I. Attendance/Call to Order

Acting Chair Hammock called the meeting to order.

Present: Acting Chair M. Hill Hammock and Directors Ada Mary Gugenheim; Robert G. Reiter, Jr.; and Layla P. Suleiman Gonzalez, PhD, JD (4)

Directors Mary Driscoll, RN, MPH; Mary B. Richardson-Lowry; David Ernesto Munar; and Otis L. Story, Sr.

Gerald Bauman (Non-Director Member)

Absent: Chair Mike Koetting and Director Hon. Dr. Dennis Deer, LCPC, CCFC (2)

Additional attendees and/or presenters were:

Cathy Bodnar – Chief Corporate Compliance and Privacy Officer
Ryan Caldwell - RSM
Debra D. Carey – Interim Chief Executive Officer
Andrea M. Gibson – Interim Chief Business Officer
Pat Kitchen - RSM
Jeff McCutchan –General Counsel
Ammar Rizki – Chief Financial Officer of Cook County
Mary Sajdak – Chief Operating Officer of Integrated Care
Deborah Santana – Secretary to the Board
Tom Schroeder – Director of Internal Audit
Robert Sumter, PhD – Interim Deputy Chief Executive Officer, Operations and Chief Information Officer

The next regular meeting of the Audit and Compliance Committee is scheduled for Friday, September 18, 2020 at 8:30 A.M.

II. Electronically Submitted Public Speaker Testimony

There were no public testimonies submitted.

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

A. Action Item – approval of proposed CountyCare Compliance Plan

Cathy Bodnar, Chief Corporate Compliance and Privacy Officer, provided an overview of the information contained in the Report. The Committee reviewed and discussed the information.

The Report included information on the following subjects:

III. Report from Chief Corporate Compliance and Privacy Officer (continued)

- Volume Indicators
- FYTD 2020 Metrics – Cook County Health as a Provider of Health Care Services and CountyCare Medicaid Health Plan
- CountyCare Compliance Plan – Request for Approval

Director Gugenheim, seconded by Director Reiter, moved to approve the proposed CountyCare Compliance Plan. THE MOTION CARRIED UNANIMOUSLY.

IV. Report from Director of Internal Audit (Attachment #2)

A. Action Item – approval of proposed Internal Audit Charter

Tom Schroeder, Director of Internal Audit, provided an overview of the proposed Internal Audit Charter. It is being presented for the Committee's approval with no proposed changes from last year. After further discussion, the Committee determined that they would approve it, subject to final approval by Chair Koetting, who is absent from today's meeting for medical reasons.

Director Suleiman Gonzalez, seconded by Director Reiter, moved to approve the proposed Internal Audit Charter, subject to final approval by Chair Koetting. THE MOTION CARRIED UNANIMOUSLY.

V. Action Items

A. Accept Minutes of the Audit and Compliance Committee Meeting, February 21, 2020

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

VI. Closed Meeting Items

A. Report from Director of Internal Audit
B. Discussion of Personnel Matters
C. Discussion of report relating to the audit of FY2019 CCH Financial Statements and Required Communications with External Auditors

Director Suleiman Gonzalez, seconded by Director Reiter, moved to recess the open meeting and convene into a closed meeting, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and 5 ILCS 120/2(c)(**29**), regarding "meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves

VI. Closed Meeting Items (continued)

internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America."

On the motion to recess the open meeting and convene into a closed meeting, a roll call was taken, the votes of yeas and nays being as follows:

Yeas: Acting Chair Hammock and Directors Gugenheim, Reiter and Suleiman Gonzalez (4)

Nays: None (0)

Absent: Chair Koetting and Director Deer (2)

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

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

VII. Adjourn

As the agenda was exhausted, Acting Chair Hammock declared the meeting ADJOURNED.

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

XXXXXXXXXXXXXXXXXXXXXX
M. Hill Hammock, Acting Chair

Attest:

XXXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

Requests/Follow-up:

There were no requests for follow-up made at the meeting.

Cook County Health and Hospitals System
Minutes of the Audit and Compliance Committee Meeting
June 19, 2020

ATTACHMENT #1

Corporate Compliance Report

Audit & Compliance Committee of the Board of Directors

June 19, 2020

COOK COUNTY HEALTH

Meeting Objectives

Review

Volume Indicators

- F-YTD 2020 Metrics
  - Cook County Health as a Provider of Health Care Services
  - CountyCare Medicaid Health Plan
- CountyCare Compliance Plan
  - Request for Approval

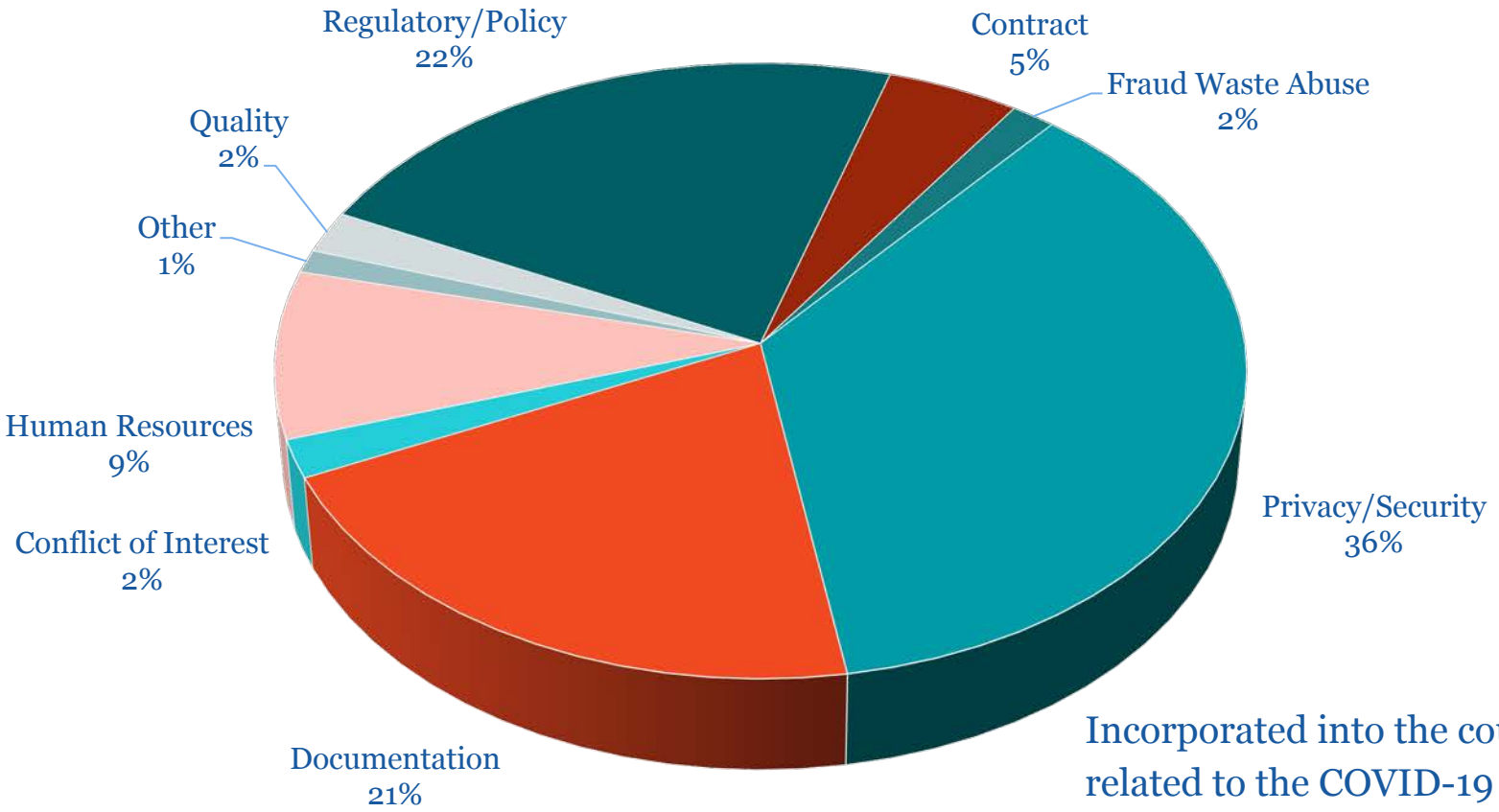
Volume Indicators

Metrics

COOK COUNTY HEALTH

F-YTD 2020 Contacts by Category

CCH as a Provider of Care – Dec 1, 2019 through May 31, 2020



Categories	
Privacy/Security (HIPAA)	181
Regulatory/Policy	112
Documentation	103
Human Resources	44
Contracts	24
Quality	11
Conflict of Interest	10
Fraud Waste & Abuse	8
Other	6
	499

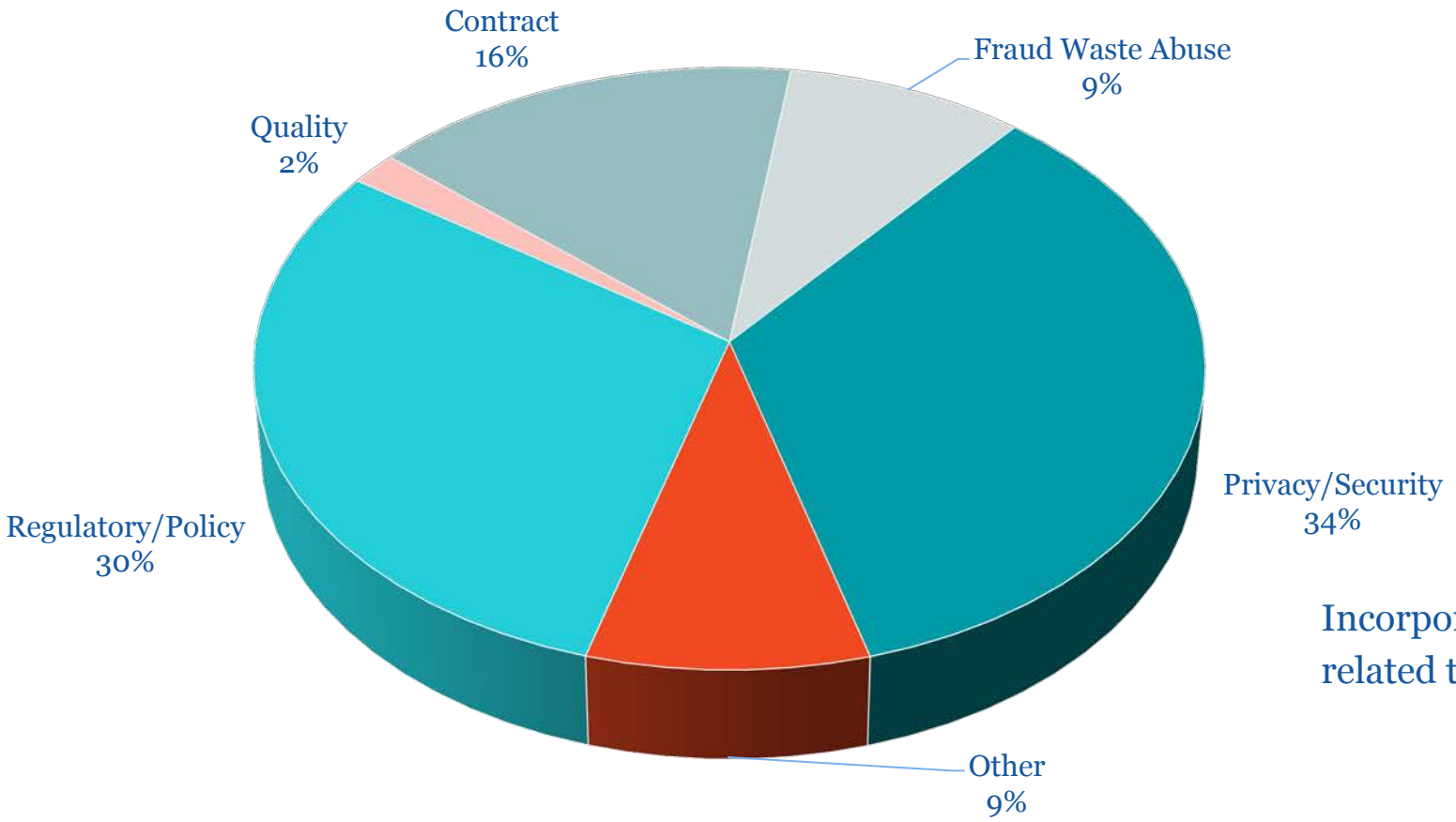
Incorporated into the counts above are **105** issues related to the COVID-19 Public Health Emergency

COOK COUNTY HEALTH

Source: CCH Compliance Tracker

F-YTD 2020 Contacts by Category

CountyCare Health Plan – Dec 1, 2019 through May 31, 2020



Categories	
Privacy/Security (HIPAA)	39
Regulatory/Policy	34
Contracts	18
Fraud Waste & Abuse	10
Quality	2
Other	10
	113

Incorporated into the counts above are **6** issues related to the COVID-19 Public Health Emergency

COOK COUNTY HEALTH

Source: CCH Compliance Tracker

CountyCare Program Integrity Activity

State Fiscal Year 2020 Q1-2-3 (July 1, 2019 – March 30, 2020)

Number of Tips[1]	Number of New SIU Investigations[2]	Number of Audits[3]	Amount of Overpayments Collected[4]
48	34	2,585	$ 1,629,520.96
48	6	5,096	$ 775,043.54
57	12	1,521	$ 1,392,335.59
		Total Collected	**$ 3,796,900.09**
		For comparison S-FY2019	*$ 1,986,699.41*

[1] Tips — Allegations of suspected Fraud, Waste, Abuse, mismanagement or misconduct by a provider or member; not vetted

[2] Investigations — Any tip that has exposure; provider or member specific

[3] Audits — Claim lines implicated by data mining or algorithms;
Data mining/algorithms are trend specific, not provider specific

[4] Overpayments Collected — Money actually recouped and in the bank; small amount may be paid back to the provider on a corrected claim

COOK COUNTY HEALTH

Source: CountyCare Compliance Reporting to HFS

CountyCare HEALTH PLAN

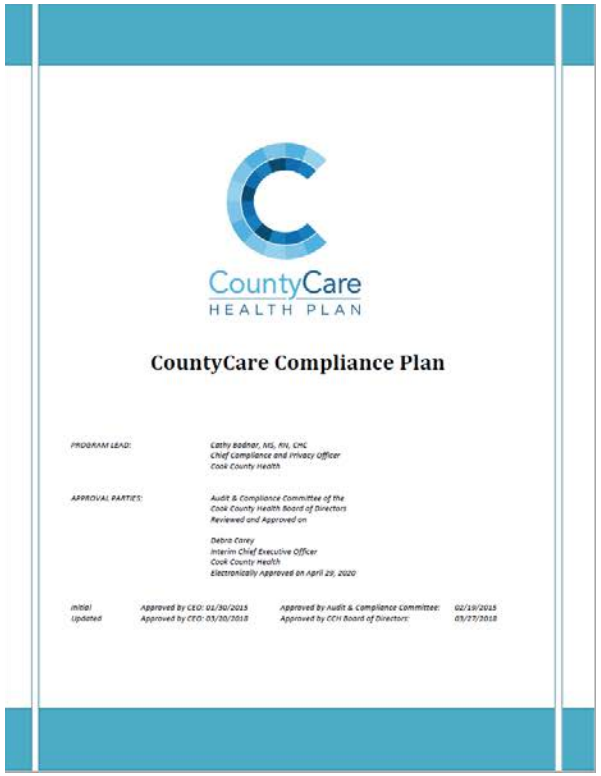
Compliance Plan

Request for Approval

COOK COUNTY HEALTH

Updated CountyCare Compliance Plan

Continues to follow the 7 elements of an effective compliance program



1. Incorporates updates required by MCCN Amendments;
2. Parallels language used by HFS;
3. Holds all partners accountable for compliance;
4. Commits to maintain confidentiality and protections for whistleblowers;
5. Strengthens fraud and abuse procedures; and
    a. Integrates the FWA Plan.

Request for approval

Questions?

COOK COUNTY HEALTH

CountyCare
HEALTH PLAN

CountyCare Compliance Plan

PROGRAM LEAD: *Cathy Bodnar, MS, RN, CHC*
Chief Compliance and Privacy Officer
Cook County Health

APPROVAL PARTIES: *Audit & Compliance Committee of the Cook County Health Board of Directors Reviewed and Approved on*

Debra Carey
Interim Chief Executive Officer
Cook County Health
Electronically Approved on April 29, 2020

APPROVED
JUN 26 2020
BY BOARD OF DIRECTORS OF THE COOK COUNTY HEALTH AND HOSPITALS SYSTEM

Initial	*Approved by CEO: 01/30/2015*	*Approved by Audit & Compliance Committee:*	*02/19/2015*
Updated	*Approved by CEO: 03/20/2018*	*Approved by CCH Board of Directors:*	*03/27/2018*

Table of Contents

1.0 Introduction

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

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

CountyCare has developed this CountyCare Compliance Plan to demonstrate its commitment to promoting ethical and lawful conduct consistent with all applicable laws, regulations, and contractual requirements, as well as CCH policies, procedures, and Code of Ethics/Standards of Conduct. The CountyCare Compliance Plan is structured around the seven (7) elements of an effective compliance program as required by Section 5.35 of the County MCCN Contract with HFS and as recommended in the Department of Health and Human Services Office of Inspector General ("OIG") Compliance Program Guidance publications and required by the Centers for Medicare & Medicaid Services ("CMS") Managed Care Program Integrity requirements found at 42 C.F.R. §438.608. Upon implementation, the CountyCare Compliance Plan will be managed and maintained by the CCH Office of Corporate Compliance. The Compliance Plan will be submitted to the HFS Office of Inspector General ("HFS OIG") for prior approval on an annual basis.

2.0 Purpose

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

Further, the CountyCare Compliance Plan outlines guidelines to:

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

3.0 Definitions and Abbreviations

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0 CountyCare Compliance Plan Overview

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

5.0 CountyCare Compliance Plan Elements

CountyCare's Compliance Plan incorporates the seven elements of an effective compliance program as mandated by Section 5.35 of the County MCCN Contract with HFS and the CMS Managed Care Program Integrity requirements. It includes the following specific controls to ensure CountyCare meets all federal, state, and contractual requirements. Elements of CountyCare's Compliance Plan include:

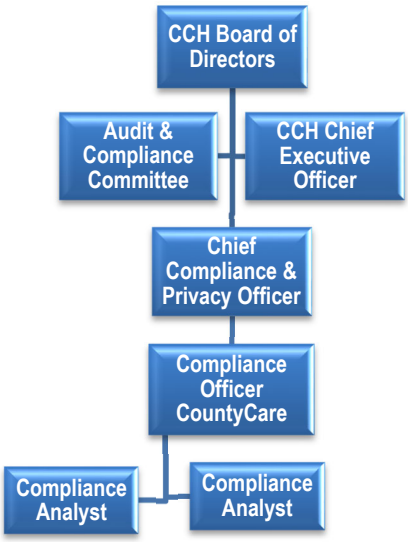
1. **Written Policies, Procedures and Standards of Conduct.** The CCH Code of Ethics applies to all CountyCare Personnel, Providers, and Subcontractors. The Code of Ethics, as well as CCH's policies and procedures, support CountyCare's commitment to comply with all federal and state standards, governing program integrity and the detection and prevention of fraud, waste, abuse, mismanagement, and misconduct including but not limited to, applicable statutes, regulations and sub-regulatory guidance and contractual requirements.

   CountyCare Personnel have access to compliance policies and procedures via the CCH intranet portal. CountyCare compliance policies and procedures address various components of program integrity including but not limited to the following subject areas:

   - Code of Ethics
   - Corporate Compliance Mission and Vision Statement
   - Compliance Program operations, including:
     - Position Descriptions
     - Board, Committee and Subcommittee Charter Statements
     - Mandatory Training Requirements (for new workforce members and annual training)
     - Compliance Hotline and Methods for Communication
     - Excluded Providers Sanction Screening
     - Compliance Auditing and Monitoring
     - Compliance Investigations
     - False Claims Act and Whistleblower Protections
   - Fraud, Waste, Abuse and related policies, including:
     - Fraud, Waste and Abuse Reporting and Non-Retaliation
     - Overpayment and Recovery of Claims
     - Provider Preventable Conditions
     - Recipient Restriction
     - Recipient Verification of Services Rendered by Provider
     - Fulfilling Data Requests and Acting Upon Provider Alerts Policy
     - Conflict of Interest
   - Confidentiality, Privacy and Security (HIPAA) Policies

   Delegated vendors (Subcontractors) are contractually required upon initiation of contract and annually, assure consistency and adherence to the CCH Code of Ethics and CountyCare's Corporate Compliance Program policies. Similarly Network Providers have contractual requirements upon initiation and annually to abide by and cooperate with CountyCare's Fraud, Waste, Abuse, mismanagement or misconduct program, which is consistent with CountyCare's policy, procedures, State and federal law. The Provider contract along with the Provider Manual and in conjunction with the network services team communicates requirements and provide updates.

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



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

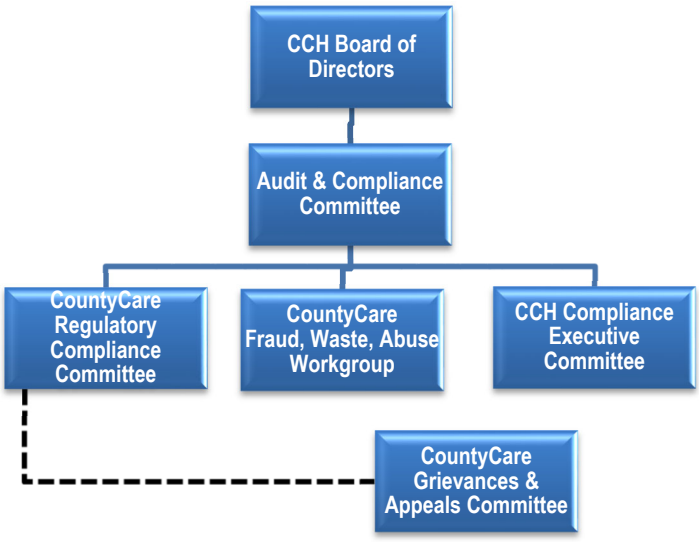
- The CountyCare Compliance Plan;
- Development and implementation of policies, procedures and practices designed to ensure compliance with the County MCCN Contract with HFS, including requirements related to program integrity;
- Operational compliance with the complaint, grievance, appeals, and fair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

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

- Overseeing the implementation of CountyCare Compliance Plan;
- Providing oversight and guidance regarding CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary;
- Updating members on regulatory, contractual and statutory matters affecting Compliance activities of CountyCare;
- Meeting on a regular basis, no less than quarterly, and as needed;
- Appointing a liaison to HFS to report potential fraud, abuse, or financial misconduct;
- Ensuring compliance with monthly and quarterly CountyCare Health Plan fraud, abuse, mismanagement and financial misconduct reporting requirements; and,
- Reporting to both the CCH Compliance Executive Committee, the CCH Board of Directors, through the Audit & Compliance Committee of the Board, and the CEO.

The CCH Audit & Compliance Committee of the Board is tasked with general support and oversight of the CountyCare Regulatory Compliance Plan operations and compliance with the County MCCN

Contract. The CCH Chief Compliance and Privacy Officer and Compliance Officer, CountyCare provide reports to the Audit & Compliance Committee of the Board on a regular basis on the operations and effectiveness of the Compliance Program. Members of senior leadership of CountyCare attend meetings of the Audit & Compliance Committee of the Board on an as needed basis.



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

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

   Subcontractors (delegated vendors) are contractually required upon initiation of contract and annually, assure consistency and adherence to the CCH Code of Ethics and CountyCare's Corporate Compliance Program policies.

4. **Effective Lines of Communication.** CountyCare has implemented clear policies and procedures for reporting concerns related to compliance, integrity, and fraud, waste, abuse, mismanagement and misconduct. All Personnel, Providers and Subcontractors have a duty to report misconduct including actual or potential violations of law, regulation, policy, procedure or the CCH Code of Ethics to the Chief Compliance and Privacy Officer. Failure to report a violation may result in appropriate

disciplinary action. Personnel, Providers and Subcontractors are protected from retaliation and harassment as a result of having reported a good faith compliance or integrity concern. CountyCare maintains procedures for reporting instances of suspected fraud, waste, abuse, mismanagement and misconduct to HFS and OIG. Additionally, CCH makes regular communications to its Personnel and Subcontractors regarding compliance information and updates.

Communication mechanisms utilized by CountyCare include:

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

CountyCare has also implemented effective lines of communication between the Chief Compliance and Privacy Officer, Compliance Officer, CountyCare, Personnel, Subcontractors and the HFS OIG.

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

6. **Monitoring and Auditing.** CountyCare has implemented a monitoring and auditing program which includes written policies and procedures for routine internal monitoring as well as oversight auditing by the CCH Office of Corporate Compliance. The monitoring and auditing program tests and confirms compliance with CMS and HFS managed care requirements, regulatory guidance, contractual agreements, program integrity compliance risks and applicable federal and state laws, as well as internal policies and procedures to protect against non-compliance and potential fraud, waste, abuse, mismanagement and misconduct. Additionally, regular audits of Subcontractors and Providers are conducted to ensure compliance with contractual and regulatory requirements and program integrity compliance risks. Auditing and monitoring activity is conducted in accordance with the annual Compliance Work Plan, developed and approved by the CountyCare Compliance Oversight Committee, with input from the CCH Compliance Executive Committee, CCH Board of Directors, through the Audit and Compliance Committee of the Board. The CCH Office of Corporate Compliance will conduct an investigation of any potential compliance problems identified in the course of self-evaluation and audits and ensures that identified compliance problems are mitigated through the use of corrective action plans. Results of monitoring and auditing activities, and subsequent corrective action plans, are reported to the CountyCare Compliance Oversight Committee, the CCH Compliance Executive Committee, and the CCH Board of Directors, through the Audit and Compliance Committee of the Board.

7. **Prompt Response to Detected Offenses.** CountyCare has established and implemented communication methods that are available 24x7 to enable Personnel and Subcontractors to report

program non-compliance, program integrity issues and potential fraud, waste, abuse, mismanagement and misconduct without fear of retaliation. Consistent with HFS contractual requirements for responding to reports of potential fraud, waste abuse, mismanagement or misconduct, CountyCare has established and implemented a process that includes: routine monitoring of communication avenues, reporting such instances to the OIG within three (3) days after receiving such report, cooperating with OIG investigations, and developing and implementing appropriate corrective or disciplinary actions, if necessary.

6.0 Reporting Compliance Concerns

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

- CountyCare Member Services Call Center: **1-312-864-8200**
- CountyCare Fraud, Waste and Abuse Hotline: **1-844-509-4669**
- CCH Corporate Compliance Hotline: **1-866-489-4949**
- CCH Corporate Compliance online reporting portal: www.cchhs.ethicspoint.com

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

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

7.0 Fraud and Abuse Procedures

CountyCare is dedicated to preventing, detecting and reporting health care fraud, waste, abuse, mismanagement and misconduct, as is required by federal and state statutory, regulatory and contractual obligations. Each benefit administrator Evolent Health LLC (medical and behavioral health), MedImpact (pharmacy), Guardian Avesis (dental/vision) and First Transit (transportation) is similarly committed to attaining and maintaining compliance with Federal, State and Local laws, regulations and other guidance that are applicable to the State of Illinois Medicaid program that includes fraud, waste and abuse detection and prevention. Each benefit administrator has established a Fraud, Waste and Abuse program which is designed to prevent, detect and correct Fraud, Waste, Abuse (FWA), mismanagement and misconduct as it relates to the administration of its corporate business and contracts. As such, there are multiple policies, processes and procedures in place to prevent, detect, investigate and report, as necessary, suspected instances of fraud, waste, abuse, mismanagement and misconduct involved in CountyCare operations. Additionally, where these instances arise, CountyCare has an affirmative contractual obligation to report this information to the HFS OIG within three (3) days after receiving such report.

Fraud, Waste, Abuse, Mismanagement, and Misconduct Monitoring Procedures

CountyCare, in coordination with its benefits administrators, has developed and implemented the following fraud and abuse procedures:

- All CountyCare Subcontractors delegated responsibility for coverage of services or payment of claims for CountyCare shall implement and maintain a compliance program.
- All CountyCare network providers are required to comply with the Program Integrity requirements outlined within Section 5.35 of the County MCCN Contract with HFS.
- CountyCare network providers are also required to report to CountyCare when they have received an overpayment from CountyCare. The provider is required to return the identified overpayment to CountyCare within sixty (60) days of identifying the overpayment and notify CountyCare in writing the specific reason for the overpayment and how the overpayment was identified by the provider.
- All CountyCare Personnel, Providers, and Subcontractors are contractually required to report any instances of suspected or actual fraud, waste, abuse, mismanagement, and misconduct.
- Payment Integrity (PI) efforts dedicated to detecting, preventing and recovering potential Fraud Waste and Abuse payments, including claims edits, prepayment and post-processing review of claims. CountyCare has established and implemented a policy and procedure to identify and recover overpayments (Fraud, Waste and Abuse: Adjudication of Incorrect Claims Payments.)
- Special Investigation Units (SIU) operations, including the use of surveillance and utilization controls to identify, investigate, remediate and report instances of Fraud, Waste and Abuse, as required by the CountyCare agreement and the State.
- Employment of Fraud, Waste and Abuse Investigators at a minimum ratio of one (1) Investigator to every one hundred thousand (100,000) enrollees.
- Member Service Verification Letters are sent to members to identify phantom providers or services that were not performed.
- All Personnel, Subcontractors and Providers are required to take fraud, waste, and abuse training that explains the procedures for reporting, as well as provide background information and examples of possible fraud, waste, abuse, mismanagement or misconduct.
- Sanction and Exclusion Screening is performed for all CountyCare Personnel, and Subcontractors upon hire and monthly. CountyCare will terminate a Subcontractor when notified by the OIG pursuant to Section 5.32.10.3 of the County MCCN Contract with HFS.
- Regular oversight is exercised over Subcontractors and delegated entities (also known as vendor oversight) to ensure any potential issues that are detected and reported by contractors and vendors are appropriately identified, investigated and remediated, using corrective action plans when necessary.
- Fraud, Waste, Abuse Workgroup meetings are convened on an ad-hoc basis.
- Quarterly CountyCare Regulatory Compliance Committee meetings are held to discuss new and outstanding Compliance issues, including FWA updates, and to provide oversight and guidance of CountyCare operations to fulfill Compliance program requirements and monitor corrective action plans as necessary.
- Timely submission of reports regarding any suspected criminal fraud, waste, abuse, mismanagement or misconduct by CountyCare members, Providers, Personnel or Subcontractors to the HFS OIG to the OIG within three (3) days after receiving such report.
- This includes all internal and external observations or reports that have potential implications of Network Provider billing anomalies, and, potential risk of harm concerns for all members.

CountyCare shall take steps to triage and substantiate such information and provide timely updates to the HFS OIG, and ISP-MFCU when concerns or allegations are authenticated.

- Prompt submission of reports regarding any potential Fraud, Waste, Abuse, mismanagement, or misconduct to the HFS OIG.
- Timely submission of reports regarding any information that may affect a member's eligibility to participate in the Medical Assistance program, including changes in a member's address or death of a member, to the HFS OIG within ten (10) business days of receiving the information.
- Timely submission of reports regarding any information about a change in a Network Provider's circumstances that may affect the Provider's eligibility to participate in the Medical Assistance Program, including termination of the Contractor's Provider agreement, to the HFS OIG within ten (10) business days of receiving the information
- Submission of monthly reports notifying the HFS OIG of any program integrity case opened within the previous month;
- Submission of quarterly reports outlining all instances of suspected fraud, waste, abuse or financial misconduct to the HFS OIG.

A separate Fraud Waste and Abuse Plan is appended to this document.

8.0 Procedures for Confidential Information

CountyCare is dedicated to providing safeguards and protections for confidential information received and used in its health plan operations, as is required by federal and state statutory, regulatory and contractual obligations.

CountyCare Personnel, and Subcontractors (delegated vendors) may have or may gain access to Confidential Information (as defined in Section 1.1.40 the County MCCN Contract with HFS) or data owned or maintained by the HFS in the course of carrying out its responsibilities under its County MCCN Contract with HFS. CountyCare Personnel, and Subcontractors (delegated vendors) will presume that all information received from the State or HFS, or to which it gains access pursuant to the County MCCN Contract, is confidential.

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

No confidential data collected, maintained, or used in the course of performance of the County MCCN Contract shall be disseminated by CountyCare Personnel, and Subcontractors (delegated vendors), except as authorized by law and with the written consent of the State/HFS, either during the term of the County MCCN Contract or thereafter, or as otherwise set forth in the County MCCN Contract.

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

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

- Are lawfully in the CountyCare's possession prior to its acquisition from HFS/the State;

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

9.0 Cooperation with External Regulators and Enforcement Agencies

CountyCare, and its employees, agents, providers and delegated vendors shall cooperate fully in any investigation or prosecution by any duly authorized government agency, whether administrative, civil, or criminal. Such cooperation shall include providing, upon request, information, access to records, and access to interview CountyCare's employees and consultants, including but not limited to those with expertise in the administration of the Medical Assistance Program, in medical or pharmaceutical questions, or in any matter related to an investigation.

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

Addendum Fraud Waste and Abuse Plan

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

CountyCare
HEALTH PLAN

Fraud, Waste and Abuse Plan

PROGRAM LEAD:

Cathy Bodnar, MS, RN, CHC
Chief Compliance and Privacy Officer
Cook County Health

Contents

1.0 Overview

In connection with the CountyCare Health Plan, each benefit administrator, Evolent Health LLC (medical and behavioral health), MedImpact (pharmacy), Guardian Avesis (dental/vision) and First Transit (transportation) is committed to attaining and maintaining compliance with Federal, State and Local laws, regulations and other guidance that are applicable to the State of Illinois Medicaid program that includes fraud, waste and abuse detection and prevention. Each benefit administrator has established a Fraud, Waste and Abuse program which is designed to prevent, detect and correct Fraud, Waste, Abuse (FWA), mismanagement and misconduct as it relates to the administration of its corporate business and contracts. This activity occurs under the purview of the Compliance Officer, CountyCare with oversight by the Chief Compliance and Privacy Officer. Ultimately the Compliance Officer, CountyCare is responsible for the FWA Program, serves as the liaison to the Department and has the affirmative duty to timely report within 3 days to the HFS OIG any suspected criminal Fraud, Waste, Abuse, mismanagement or misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees.

All employees, subcontractors and vendors have the responsibility to identify, investigate and report potential fraud, waste, abuse, mismanagement or misconduct activities.

More specifically, directors, and employees, contractors, subcontractors, providers, and members are expressly prohibited from:

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

The Fraud, Waste and Abuse Plan is designed to:

- Describe methods to identify, prevent, review and take corrective action against any provider or member who is suspected of participating in FWA activities;
- Implement systems for identifying patterns or instances of suspicious provider or member activity;
- Provide guidance, education, training related to FWA processes, including mechanisms to report FWA;
- Receive reports of provider or member misconduct from other entities and external sources; and
- Provide information to Health Plan to report potential incidents of FWA to applicable state and/or federal agencies.

CountyCare may conduct investigations of suspected Fraud, Waste, Abuse, mismanagement or misconduct of its personnel, Providers, Subcontractors, or Enrollees only to the extent necessary to determine whether reporting to the OIG is required, or when CountyCare/Valence has received the express concurrence of the OIG. If the investigation discloses potential criminal acts, the Compliance Officer, CountyCare shall immediately notify the OIG.

2.0 Fraud, Waste and Abuse Plan

The Fraud, Waste and Abuse Plan demonstrates CountyCare's commitment to prevent, detect and correct incidents with a potential for leading to FWA. This FWA Plan describes the process followed to identify, investigate, prevent, refer and report suspected or potential FWA, in compliance with 42 CFR 455.13, 455.14 and 455.21. Regular audits of provider and member activity will be performed to ensure fraudulent activity is recognized and to proactively identify areas which may be susceptible to potential FWA.

The following are compliance resources to prevent, detect, mitigate, and disclose violations of law, the Code of Ethics, Company policies and procedures, or other forms of fraud, waste, abuse, mismanagement and misconduct. These include:

1. The Code of Ethics
2. The Compliance Department
3. Computerized training
4. Externally contracted FWA prevention and detection services

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

Ultimately, the Compliance Officer, CountyCare has the affirmative duty to report to the HFS OIG in a timely way suspected fraud, waste, abuse, mismanagement, and misconduct in the HFS Medical Program by Enrollees, Providers, Contractor's employees, or Department employees. The FWA Plan is implemented throughout internal operations and includes subcontractors, as well as any contracted, external provider networks. Each benefit administrator enforces the FWA Program through the following activities:

1. Establishment of standards, policies, and procedures to address FWA;
2. Establishment and implementation of an effective FWA program, including data analytics, for routine auditing and monitoring of FWA;
3. Assignment of oversight responsibility for the FWA Plan;
4. Effective education and training;
5. Monitoring of contractual activities related to FWA;
6. Development of lines of communication for reporting violations and clarifying policy regarding FWA; and
7. Publicizing disciplinary standards.

Core Elements

The FWA Plan includes the following core elements, which are necessary to have an effective program:

- FWA prevention and detection processes;
- FWA training and education to employees and subcontractors, as applicable;

- Methods to identify, prevent, review and promptly respond to risks and finding and take appropriate corrective action against any employee, vendor, provider or member who is suspected of participating in FWA activities;
- Enforcement and Discipline;
- Oversight of subcontractors, vendors and/or providers related to FWA requirements;
- Oversight and remediation of members who may not be utilizing the benefits appropriately such as: pharmacy, providers, durable medical equipment, medications, medical supplies, appliances, equipment and other health care services. Member remediation efforts are commonly referred to as the Recipient Restriction Program or member "lock-in;" and
- Reporting identified FWA issues.

Written Policies and Procedures

The FWA Plan includes the following core elements, which are necessary to have an effective Valence's written Compliance Policies and Procedures represent commitment to honest, ethical, and responsible business conduct in compliance with Federal and State laws and regulations and professional standards.

Structure

Policies and procedures are written to provide detailed and specific information regarding the Fraud, Waste and Abuse Plan. Each policy and procedure provides documentation of operational compliance and each is an integral part of the program. FWA Policies and Procedures include but are not limited to:

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

FWA Plan Distribution, Updates and Revisions

- Reviews and updates to the FWA Plan occur at least annually, and as needed and incorporates changes to previously enacted law(s), new law(s), and changes in the healthcare industry.
- Each workforce member and subcontractor receives training on FWA within 60 days of hire or contract and annually.
- FWA policies and procedures that support the FWA Plan are maintained electronically on a Cook County Health shared drive in addition to the intranet.
- All fraud, waste, abuse, mismanagement, and misconduct updates to the policies and procedures by benefit administrators are approved by the Compliance Officer, CountyCare prior to implementation and dissemination.

FWA Referrals

CountyCare Compliance in partnership with its benefit administrators have responsibility to receive and act upon FWA referrals from various sources, including but not limited to the following:

- **Hotline:** A toll-free hotline number has been established to report potential FWA activities. The FWA hotline is operated by an independent third party and all referrals are sent directly to the Compliance Department's management and other members of the SIU, as applicable. All hotline referrals receive a case number within one (1) business day.

- **State/Federal Notifications**: Notifications may be received during periodic communications and meetings with the State. During meetings, other MCOs and state/federal employees may provide information regarding a provider which will result in a preliminary review. This may include, but will not be limited to, Insurance Divisions, Board of Physicians Quality Assurance, Attorney General's Office, US Postal Inspector, etc.

- **Claim Edits:** CountyCare utilizes a claims editing system to reduce reimbursement errors and improve payment integrity. The claims editing system methodically checks CountyCare claims for errors, omissions, and questionable coding relationships and tests the data against government and industry rules, regulations, and policies governing healthcare claims.

- **Data Mining by SIU for trends**: Data analytics is critically important to identify potential FWA. Using tools available, the dedicated benefit administrator team detects and deploys the most effective means to avoid and mitigate FWA for the Illinois Medicaid program. The tool refines and customizes the data analytics approach based on Illinois Medicaid policy to maximize identification and detection of FWA. Monitoring and acting upon national trends with data mining helps to identify similar trends in Illinois. This proactive approach allows for prevention of potential FWA for the Medicaid program.

- **Investigators/Coders/Clinical Reviewers**: Investigators, certified professional coders and clinical staff that assist with the review of CountyCare records when further review needs to be conducted from referrals or from data mining activities. The medical record review process consists of reviewing medical records against claims submitted and payments made to ensure payment accuracy for services performed. The provider has the opportunity to review and provide additional information or appeal before any action for recoupment is taken by the Health Plan.

- **Exclusion/Sanction Investigations**: Valence will screen all current and prospective employees, contractors, and sub-contractors, prior to engaging their services by: (i) requiring them to disclose whether they are Excluded Persons; and (ii) reviewing the following databases;

    - System for Award Management (SAM) maintained by the United States General Services Administration (GSA);
    - The DHHS/OIG List of Excluded Individuals/Entities at https://exclusions.oig.hhs.gov/;
    - The Federal CMS Data Exchange System (DEX);
    - Others as required by contract with individual health plans.

Reporting

- All directors, contractors and subcontractors have an affirmative obligation to immediately report suspected violations of law, the Code of Ethics, policies and procedures, or other forms of fraud, waste, abuse, mismanagement or misconduct to appropriate personnel, including a supervisor or manager, the Compliance Officer, or the CEO.

- Where required by law or contract requirements, the Compliance Officer may directly disclose instances of potential fraud, waste or abuse to appropriate government agencies through the Compliance Department, OIG, or the General Counsel.

Non-Retaliation

- Directors, employees, and contractors are prohibited from taking any retaliatory action against any person who provides a good faith report of unlawful activity or other form of fraud, waste, abuse, mismanagement, and misconduct or who participates in any internal or external investigations of such reports. Retaliation is also prohibited against any person who files and/or participates in a whistleblower suit brought under the federal or any state false claims act.

Corrective Action, Sanction, Prosecution and Recovery

- Implementation of the appropriate corrective action is necessary and required. It may include including prosecution and recovery. Corrective Actions shall include, but not be limited to the following:
    a. **Corrective Action**: If an investigation leads to the discovery of behavior that is objectionable, but does not rise to the level of FWA, non-legal corrective action may be commenced.
    b. **Prosecution/Recovery**: If an investigation leads to the discovery of actual or suspected fraud, the suspected fraudulent behavior shall be reported immediately to the appropriate regulatory agency. CountyCare is committed to assist the regulatory agency in any way possible to resolve the matter.
        I. Workforce members who are found to be hindering or obstructing an ongoing investigation will face severe disciplinary action, including possible termination;
        II. During an investigation, all workforce members shall be notified of a hold on the destruction of any documents. Any workforce member found to be destroying documents while a hold is in effect will face disciplinary measures up to and including termination and possible criminal penalties;
        III. Workforce members may be asked to testify in the event the regulatory agency prosecutes any suspected fraudulent behavior. The workforce member should then contact the Compliance Officer, who will seek immediate further guidance from legal counsel.

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

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

- Provider Participation Sanctions may include Denial, Suspension, Termination, or Exclusion.

- In general, under federal law, no payment will be made by Medicare, Medicaid or any of the other Federal health care programs for any item or service furnished by an excluded individual. 42 CFR §1001.1901(b)(1); 305 ILCS 5/12/4.25(E)(1); 89 Ill. Adm. Code 140.15.

Prepayment Review

- In the event that CountyCare subjects a Network Provider to prepayment review or any review requiring the provider to submit documentation to support a claim prior to CountyCare considering it for payment as a result of suspected Fraud, Waste, Abuse, mismanagement, or misconduct, CountyCare shall adhere to the following within ninety (90) days of requiring such action:
  a. Conduct a medical and coding review on the claims subject to prepayment review. When Fraud, Waste, Abuse, mismanagement, or misconduct is still suspected after conducting the review, CountyCare should submit to the HFS OIG a suspected Fraud referral, including all referral components as required by the HFS OIG.
  b. A prepayment review shall not be conducted for a Provider listed as under investigation or litigation involving the federal or state government or other circumstances as deemed appropriate by the HFS OIG.

State and/or Federal Reporting Requests

- Upon completion of a review, State guidelines are followed in accordance with reporting. If a state or federal agency requests additional information or information regarding another provider, CountyCare responds within 24 hours.

Confidentiality

- Upon completion of a review, State guidelines are followed in accordance with reporting. If a state or federal agency requests additional information or information regarding another provider, Reviews are considered confidential regardless of how the issue under review was identified. The CountyCare Compliance and the benefit administrators team's dedicated to FWA will only discuss a review with the health plan representatives and/or individuals who may have direct knowledge of the potential area of concern or those individuals with FWA oversight responsibility.

Lines of Communication

- CountyCare Compliance works diligently to foster a culture of compliance throughout the organization by regularly communicating the importance of conducting all business activities in compliance with all laws and regulatory requirements and professional standards and reinforcing the expectation of ethical, honest, transparent, effective, and responsible behavior of all employees.
- CountyCare has systems in place to receive, record, and respond to FWA inquiries or reports of potential or suspected FWA by employees, workforce members and vendors.

Cook County Health and Hospitals System
Minutes of the Audit and Compliance Committee Meeting
June 19, 2020

ATTACHMENT #2

Audit and Compliance Committee

Internal Audit

June 19, 2020

COOK COUNTY HEALTH

Internal Audit

Open Meeting

Internal Audit Charter

COOK COUNTY HEALTH

Internal Audit Charter

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

INTERNATIONAL STANDARDS FOR THE PROFESSIONAL PRACTICE OF INTERNAL AUDITING (STANDARDS)

Attribute Standards

1000 – Purpose, Authority, and Responsibility
The purpose, authority, and responsibility of the internal audit activity must be formally defined in an internal audit charter, consistent with the Definition of Internal Auditing, the Code of Ethics, and the Standards. **The chief audit executive (CAE) must periodically review the internal audit charter and present it to senior management and the board for approval.**

Interpretation:
The internal audit charter is a formal document that defines the internal audit activity's purpose, authority, and responsibility. The internal audit charter establishes the internal audit activity's position within the organization, including the nature of the chief audit executive's functional reporting relationship with the board; authorizes access to records, personnel, and physical properties relevant to the performance of engagements; and defines the scope of internal audit activities**. Final approval of the internal audit charter resides with the board.**

Internal Audit Charter

1110 – Organizational Independence

The chief audit executive must report to a level within the organization that allows the internal audit activity to fulfill its responsibilities. **The chief audit executive must confirm to the board, at least annually, the organizational independence of the internal audit activity.**

Interpretation:

Organizational independence is effectively achieved when the chief audit executive reports functionally to the board. Examples of functional reporting to the board involve the board:

- **Approving the internal audit charter;**
- **Approving the risk based internal audit plan;**
- **Approving the internal audit budget and resource plan;**
- **Receiving communications from the chief audit executive on the internal audit activity's performance relative to its plan and other matters;**
- Approving decisions regarding the appointment and removal of the chief audit executive;
- Approving the remuneration of the chief audit executive; and
- Making appropriate inquiries of management and the chief audit executive to determine whether there are inappropriate scope or resource limitations.

Internal Audit Charter

Considerations for Implementation

Based on this foundational work, the CAE (or a delegate) drafts an internal audit charter. The IIA offers a model internal audit activity charter that may be used as a guide. Although they vary by organization, charters typically include the following sections:

Introduction – to explain the overall role and professionalism of the internal audit activity, citing the relevant elements of the International Professional Practice Framework (IPPF).

Authority – to specify the internal audit activity's full access to the records, physical property and personnel required to perform its engagements and to declare its accountability for safeguarding assets and confidentiality.

Organization and Reporting Structure – to document the CAE's reporting structure. The CAE reports functionally to the board and administratively to a level within the organization that allows the internal audit activity to fulfill its responsibilities. This section may delve into specific functional responsibilities, such as approving the charter and audit plan, and hiring, compensating, and terminating the CAE; as well as administrative responsibilities, such as supporting information flow within the organization or approving human resource administration and budgets.

Independence and Objectivity – to describe the importance of internal audit independence and objectivity and how these will be maintained, such as prohibiting internal audit from having operational responsibility or authority over areas audited.

Responsibilities – to lay out major areas of ongoing responsibility, such as defining the scope of assessments, writing an audit plan and submitting it to the board for approval, performing assessments, communicating the results, providing a written audit report, and monitoring corrective actions taken by management.

Quality Assurance and Improvement – to describe the expectations for maintaining, evaluating, and communicating the results of a quality program that covers all aspects of the internal audit activity.

Signatures – to document the agreement between the CAE, a designated board representative, and the individual to whom the CAE reports, with the date, name, and title of signatories.

Thank you.

COOK COUNTY HEALTH

Cook County Health (CCH)
Internal Audit Charter **March 15, 2019**

Mission

Internal Audit is an independent, objective assurance and consulting activity designed to add value and improve an organization's operations. It helps an organization accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes.

Internal Audit will align its activities with the mission and strategy of CCH. Internal Audit will promote good controls and serve as an educational resource to its stakeholders with respect to risk management, control and governance processes. Internal Audit will maintain a collaborative approach to its work practices and will ensure its work product provides value added outputs for its stakeholders.

Role

- Internal Audit's role is determined by the CCH Board of Directors through its Audit and Compliance Committee.
- Internal Audit's responsibilities are defined by the CCH Board of Directors through its Audit and Compliance Committee.

Professional Standards

- Internal Audit will govern themselves by adherence to the Institute of Internal Auditor's "Code of Ethics". http://www.theiia.org/guidance/standards-and-guidance/ippf/code-of-ethics/english/
- The Institute's "International Professional Practice Framework" shall constitute the operating procedures for the department. These documents are considered an addendum to this Charter. http://www.theiia.org/guidance/standards-and-guidance/ippf/standards/
- Internal Audit will adhere to all CCH policies and procedures and all Internal Audit procedure manuals.

Authority

Internal Audit is authorized to:

- Have unrestricted access to all functions, records, property and personnel.
- Have free, open, and timely access to the Chief Executive Officer and the CCH Board of Directors through its Audit and Compliance Committee.
- Allocate department resources, set frequencies, select subjects, determine scope of work and apply the techniques required to achieve audit objectives.
- Obtain the necessary assistance of personnel in the organization when performing audits, as well as other specialized services from within or outside the organization.

Independence

- All audit activities shall remain free of influence by any element in the organization, including matters of audit scope, procedures, frequency, timing, or report content, required to permit the independence required to render objective reports.
- Internal auditors shall have no operational responsibility or authority over any activities they review.
- Internal auditors shall not develop or install systems or procedures, prepare records or engage in any other activity that they would normally audit.

- Internal Audit reports functionally to the CCH Board of Directors through its Audit and Compliance Committee and administratively to the Chief Executive Officer.
- Internal Audit periodically reports to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership as outlined in the section on Accountability.

Accountability

Internal Audit is accountable to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership to:

- Report significant issues related to the process for controlling the activities of the organization, including potential improvements to those processes, and provide information concerning such issues through resolution.
- Provide information periodically on the status and results of the annual audit plan and the sufficiency of internal audit resources.
- Coordinate with and provide oversight of other control and monitoring functions.

Audit Scope

The scope of the work of Internal Audit is to determine whether the network of risk management, control and governance processes, as designed and represented by management, is adequate and functioning in a manner to ensure:

- Risks are identified and managed.
- Interaction with various governance groups occurs as needed.
- Significant financial, managerial and operating information is accurate, reliable and timely.
- Employee's actions are in compliance with policies, standards, procedures and applicable laws and regulations.
- Resources are acquired economically, used efficiently, and adequately protected.
- Programs, plans and objectives are achieved.
- Quality and continuous improvement are fostered in control processes.
- Significant legislative or regulatory issues impacting the organization are recognized and addressed properly.

Responsibility

- Develop an annual audit plan using risk-based methodology, including any risk or control concerns expressed by management, and submit the plan to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership for approval.
- Implement the audit plan and any special requests by the CCH Board of Directors, its Audit and Compliance Committee, and CCH Senior Leadership and management.
- Maintain a professional audit staff capable of meeting the requirements of this Charter.
- Establish a quality assurance program whereby the director of internal audit assures the operations of internal audit.
- Perform consulting services in addition to assurance services. Consulting services are defined as "advisory and related client services activities, the nature and scope of which are agreed with the client and which are intended to add value and improve the organization's governance, risk management and control processes without the internal auditor assuming management responsibility." Examples include counsel, advice, facilitation, and training.
- Evaluate and assess significant merging/consolidating functions and new or changing services, processes, operations and control processes, coincident with their development, implementation and/or expansion.

- Issue periodic reports to the CCH Board of Directors through its Audit and Compliance Committee and to CCH Senior Leadership summarizing results of internal audit activities.
- Inform the CCH Board of Directors through its Audit and Compliance Committee, and CCH Senior Leadership of emerging trends and successful practices in internal auditing.
- Provide the CCH Board of Directors through its Audit and Compliance Committee, and CCH Senior Leadership a list of internal audit measurement goals and results.
- Assist in the investigation of significant suspected fraudulent activities.
- Consider the scope of work of the external auditors and regulators for the purpose of providing optimal audit coverage at a reasonable cost.

Hill Hammock
Chairman of the Board

Dr. John Jay Shannon, MD
Chief Executive Officer

Tom Schroeder
Director of Internal Audit