Exhibit II - Case for Claims Audit

As part of a comprehensive and actively managed benefit plan, audits and reviews are key to ensuring the integrity of compliance to policies, Plan documents, and the Administration Agreement – this is a fiduciary responsibility of the Plan Sponsor. An audit of your self-funded plan Administrators should be conducted on a regular basis – particularly for the medical and pharmacy claims administrators (currently, Anthem/IngenioRx). Audits are not regularly performed on fully insured plans, as the insurer carries the liability – it's their money, not your money (although improper plan management can affect premiums). A periodic audit will keep an insured plan in check, to be sure that claims are being processed according to the intended benefit design, and that PGs are being met – looking at processing and payment accuracy, payment turnaround time, etc.

We know that there have been no audits performed since sometime prior to 2012, if ever. As a general rule of thumb, Segal recommends the following schedule:

- Self-funded Anthem Health Plans - audit every 2-3 years, and following any major plan changes.
- Self-funded Aetna Dental PPO and EyeMed Vision PPO Plans - audit once during the contract cycle, or following any major plan changes. If the audit confirms that all is being properly adjudicated, then you may be able to extend the timeframe between audits a bit longer, assuming no significant plan changes (particularly, with respect to the Vision plans).
- Insured Kaiser Permanente plan - audit once per contract cycle, or following any major plan changes. There are no available audit dates remaining in 2021, will have to schedule for 2022. Because liability rests with the carriers of fully insured coverages, audits would be more operational in nature and/or benefit/plan design-focused and not financial.

Segal's Benefit Audit Solutions (BAS) Practice represents a team of experts having a balance of technical depth and strategic sense along with extensive experience evaluating and auditing complex contract and benefit plans. Since 1973, Segal has been auditing insured and self-funded health plans of all sizes and benefit structures. We are unbiased - having no affiliations or partnerships with any carriers, third-party administrators, or pharmacy benefit managers (PBMs).

Our auditors are prior claim examiners with extensive backgrounds in claims processing and auditing. This experience makes them uniquely qualified to evaluate procedures, suggest improvement and ensure proper controls are in place for administration.

Each audit is designed with components specific to the type of benefits under review. The terms of the County's Agreement with the Administrator, the Administrator's audit policy, and the Confidentiality Agreement will guide the audit design with regard to sample size, selection methodology (random and/or target), and timeliness of project completion. The written report will be presented for the Administrator's review and comment prior to release to the County.

Method of Approach

Segal suggests a methodology that will select a statistically significant claims sample including random and targeted claims. The audit period will represent claims paid January-December 2020.

Our initial task is to gain an understanding of the day-to-day procedures and system controls in place for efficient and accurate claims processing; comparisons are made to industry best practices with evidence of compliance observed in the review of sampled claims.

Adjudication Procedures Review

An advance questionnaire will gather details regarding administrative procedures that are integral to proper adjudication of plan benefits and may have potential impact on claims processing. Responses are compared to the plan document, administration Agreement, and industry practices. Key topics include:

- Eligibility interface with the claims processing system and confirmation of retroactive overpayment recovery efforts.
- Confirmation of manual entry procedures and controls, requests for additional information, appeals procedures, and referral of cases for medical review.
- Detection and investigation procedures for coordination with other coverages (i.e., group coverage, Medicare, third-party liability) and subsequent follow-up procedures in place with any subcontracted vendor.
- Identification of improper billings (e.g., unbundled claims, inflated codes), fraudulent or duplicate submissions, and resulting provider investigation and/or retraining.
- Timeliness of network repricing, use of secondary networks, and designated non-contracted allowances.
- Utilization review program and case management interface with the claims processing system; our process assesses the procedural steps but does not comment on medical determinations.
- System capabilities including security of data and examiner edits guiding through the benefit determination process.
- Claim control measures in place to monitor hospital billing accuracy and case management determinations.

Statistical Sample

Assuming 150 statistical claims are chosen, and the observed error rate does not exceed 3%, our findings will provide a 93% confidence level with ±3% precision that the reported accuracy levels are a fair comparison to self-reported achievements.

Segal's sampling methodology combines stratified and random selection techniques in a fashion that provides statistical validity in both the financial accuracy and incidence (number) of claims processed without error. A stratified sampling of claims by dollar amount gives high dollar claims valid representation and provides a level of confidence in the overall financial impact of our audit findings. The following sections will be noted in our statistical results table of the report:

- Administrative accuracy (procedural)
- Financial accuracy
- Payment accuracy
- Claim processing time (turnaround time)

This process has been accepted by most carriers and third-party administrators (TPAs), as a valid comparison to their self-reported achievements. Actuarial staff provide the payment tiers from which a small sample of claims is representative of all claims within the same dollar range.

Segal's process minimizes the cost of the review, while providing statistical validity of the audit results through the following approach:

- Multiple payments for a single claim are combined;
- Negative claims (adjustments from prior periods) and zero paid claims are eliminated from the sample population, unless otherwise directed;
- The claims data is then grouped into dollar range categories;
- The number of claims and proportion of claims dollars to total dollars in each stratum are determined by actuarial staff;
- Actuaries determine the actual sum of claims to be sampled in each stratum to minimize the sum of the variance of sampled claim amounts and the variance of the assumed error rate;
- Claims to be audited are randomly selected from each stratum; and

The selection is tested for minimal variance and generated until an acceptable variance is achieved.

Electronic Analysis with Target Selection

System programming has developed over the years to where many plans experience auto-adjudication rates exceeding 90%, leaving a small percentage in the number of claims being manually determined at one or more decision points during the claims process. Assuming the benefit plan has been programmed correctly, a purely random selection process may not capture a variety of plan designs or provide an accurate assessment of examiner compliance with established administrative procedures. Therefore, Segal employs an electronic analysis to provide added value in the audit process while minimizing audit costs.

Anthem and Aetna will be asked to provide an expanded comprehensive claims data file that supports a number of in-house electronic analyses designed to identify potential deficiencies in the programming of variables between plan options as well as limitations in the plan. Although electronic data analyses provide the capability to review 100% of paid claims, they work under the assumption that all data was

properly entered into the claims system and that the examiners followed established administrative procedures.

Some administrators often limit the data fields provided for analysis; however, we anticipate Anthem and Aetna's layouts will facilitate the following reviews:

- Duplicate payment analysis to ensure resubmissions have been properly denied;
- Major Plan exclusions and limitations to validate correct system programming;
- Policy limitations analysis (e.g., number of visit limits);
- Patient out-of-pocket applications of copayments, deductibles, and coinsurance levels; and,
- Identification of potential third-party liability claims to confirm appropriate investigation and recovery efforts have been performed.

Results from our electronic queries are manually reviewed by audit staff to identify patterns of error and high cost claims that warrant further review. Suspect errors require review of hard copy documentation and system notes to validate the accuracy of electronic reports. Any identified error is assessed for cause; financial impact reports are requested where a systemic issue is found.

Virtual Claims Review

Given the current COVID-19 protocols in place, Segal will request virtual/WebEx access or claims screenshots from Administrators in lieu of the standard on-site review requirement.

Segal's auditors will reference the Plan Documents, Summary of Benefits and Coverage (SBC) documents, established administrative procedures, and industry best practice as they manually recalculate each statistical sample. The intent of any variance between the Plan Documents and the Administrator's benefit plan design documentation and pricing will be confirmed with the County and outlined in our draft report, if an issue is identified.

Using the Administrator's claims processing system and documentation (e.g., claim form, provider bill, case management documentation, etc.), Segal's auditor completes a worksheet for each sampled statistical claim as if the auditor was making the initial benefit determination, tracking the workflow of each claim from the time it is received in the office through each step of processing.

The auditor's virtual review of each statistical sample is manually reprocessed from receipt to final determination to verify:

- Claims were paid only for eligible individuals, based on plan provisions and documentation maintained in the claims system eligibility data.
- Documentation (e.g., provider bills, physician statements, utilization review decisions or penalty findings, surgical reports, etc.) was on file for claims paid and verified when necessary.
- Coordination of benefits and subrogation provisions were enforced, where applicable.
- Proper application of age, gender, and disease specific edits.

- Benefits were paid under the proper classification, diagnostic, and procedure codes, as an incorrect entry may affect payment accuracy or future benefit determinations.
- Established administrative procedures were compliant, appropriate, within industry guidelines, and followed during adjudication.
- Detection and investigation for other coverage (i.e., workers' compensation, group, Medicare, other third-party coverage) is documented.
- System edits and controls are effective in timely and accurate benefit determinations.
    - Detection of duplicate submissions for denial
    - Edits to detect improper provider billings
    - Payment was timely and made to the proper party
- Allowed amounts are based on the appropriate provider fee schedule (i.e., participating provider contract, reasonable and customary allowance for out-of-network providers) in place for the date of service.
- Arithmetic calculations are correct.
- Duplicate submissions have been properly denied.
- Adjustments (under or over payment) have been handled in a timely manner.
- High dollar claims are submitted for internal audit, and where appropriate, considered for care management; as applicable, we will seek evidence of timely stop-loss notification.
- Turnaround time for processing of claims is within contract provisions and industry standards.

Segal's auditors will submit questions and potential errors to the designated claims representatives on a daily basis; we will attempt to provide closure during our scheduled week of virtual/WebEx review time, or expiration of system access. Segal's lead auditor will provide copies of each worksheet with an error or comment to the Administrator's representatives on the last day of our review. This will assist the Administrator in its review of the draft audit report.

Report of Findings

Any identified error is assessed for cause; financial impact reports are requested where a systemic issue is found. Results from our sample will be compared to industry standards for Claim Financial, Payment, Procedural, and Overall Accuracy; variances will be explored for explanation. Should repetitive errors be identified, we will request financial impact reports from Anthem that identify the cost for all similar payment errors.

We will provide our draft report to the Administrator for review and comment; a copy of their written response is included with the final draft report presented to the County. We believe this practice promotes constructive process by all parties, allowing the Administrator an opportunity to explain their position and identify corrective action that has or will be taken.

Procedural and payment errors are displayed in table format and errors are summarized by type. For stratified selections, the projected errors will be used to calculate accuracy levels. Our report makes comparison to performance standards reflecting achievement in four categories:

- **Financial Accuracy** - The total paid dollars reviewed, minus the sum of overpayments and underpayments, are divided by total paid dollars audited.
- **Processing Accuracy** - The total number of claims processed correctly (without payment or procedural error), divided by the total number of claims reviewed. This calculation combines the following statistics:
  - *Payment error rate* - the total number of claims with overpayments and underpayments, expressed as a percentage of the total number of claims audited.
  - *Procedural error rate* - the number of incorrectly processed claims that contained no change in payment, expressed as a percentage of the total number of claims audited.
- **Payment Accuracy** - The total number of claims processed without a financial variance, divided by the total number of claims reviewed.
- **Turnaround Time** - The number of days between the dates a claim is received and the date processed (paid, denied, or pended for additional information). Turnaround time will be calculated as a comparison to administrative reports. Results will be based on electronic review of 100% of claims processed if data fields are sufficient for this purpose.

The following items may be commented upon under the heading of “Other Claim Matters”, and excluded from our analysis of processing accuracy.

- Payment errors noted on other claims not selected for review.
- Claims selected for audit and/or other claims reviewed in connection with the claim being audited that were paid according to the Administrator’s established practices which do not conflict with Plan provisions, but vary slightly from acceptable industry practices.
- Errors identified through the Administrator’s internal review process, with corrections initiated prior to the end of the audit period.

The written report documents the results of the audit process and summarizes the findings. It also includes any recommendations for improving the overall claims administration process. Our goal is to develop recommendations that address problems uncovered in the audit that will be beneficial to the efficiency and/or financial position of the plan.

Estimated Timing

Our audit team is prepared and equipped to complete these projects for the County and welcome the opportunity to discuss this very important opportunity with you to ensure your objectives are met in our proposed approach. We will be happy to discuss any necessary scope modifications to the proposed approach and provide modified fees at your request.

Due to the comprehensive nature of our audit and dependency on the vendors to provide information and review findings, as well as the vendor's contracted audit protocols, this audit may take up to six (6) to nine (9) months to complete. Please refer to the following sample timelines. Once a kick-off call with the vendors has been completed, Segal auditors will provide an updated timetable estimates and discuss the timing with the County.

Claims Audit (Medical & Dental)

Task/Deliverable*	Owner	Proposed Timing *
Notice of Award and Contract Execution	Segal	Week 1
Kick-off Call between the County and Segal Project Managers	Segal and County	Week 2
Data requests to Vendors	Segal	Week 3
Execute Audit Confidentiality Agreements	Vendors / Segal / County	Weeks 3 - 5
Provide claims data to Segal (3-4 weeks from receipt of data request)	Vendors	Weeks 6 - 7
Validate data files and submit sample selection to Vendors	Segal	Weeks 8 – 9
Retrieve documentation for sampled claims (4-6 weeks)	Vendors	Week 13 – 17
Onsite/virtual audit and operational review are performed	Segal and Vendors	Week 18 / 19
Final responses to audit questions are received (2-3 weeks following audit)	Vendors	Weeks 20- 21
Draft report released for vendor review and comment	Segal	Weeks 22 - 24
Response to draft report is received (3-4 weeks)	Vendors	Weeks 25 – 28
Draft report provided to the County for review and approval	Segal	Weeks 30 - 32
Review and approval to release final report	County	Weeks 30 - 34
Release of formal report	Segal	Week 35

*The above is a proposed timeline. Proposed weeks are tentative pending the vendors' cooperation and/or contract stipulations. Timing is contingent upon the finalizing the vendor confidentiality agreements.

Pharmacy Benefit Audit Services

Task/Deliverable	Owner	Proposed Timing *
Send data request to IngenioRx	Segal	Week 1
Call to discuss audit scope with IngenioRx	Segal/IngenioRx	Week 2
Receipt of raw claims data, financial reconciliation report, and reconciliation inclusion/exclusion claims detail from IngenioRx	IngenioRx	Weeks 3 – 6
Quality review of raw claims data, reconcile to control totals	Segal/IngenioRx	Week 8
Conduct claims audit and analysis	Segal	Weeks 9 – 19
Send preliminary technical findings to IngenioRx for investigation	Segal	Week 20
IngenioRx responds to preliminary technical findings	IngenioRx	Weeks 21 – 28
Incorporate IngenioRx's response in final audit report	Segal	Weeks 29 - 30
Issue final audit report	Segal	Weeks 31 - 34
Review final report with the County	Segal / County	TBD
Follow-up with the IngenioRx regarding any client concerns	Segal/IngenioRx	TBD

*Proposed timing is contingent on IngenioRx providing adequate data and information to complete each step in the audit process, and any delays may result in adjustments to the proposed timeline or deadline. This exchange of information includes any follow up questions or requests that may arise from IngenioRx's responses to the preliminary technical findings.

Audit Fees

Recommended for 2021

- Anthem/IngenioRx (self-insured medical/Rx): **Charge: $75,000** assumes sample size of 200 medical claims (e.g., 150 statistical and 50 target claims), and 100% of PBM claims.
- Aetna (self-funded dental PPO): **Charge: $50,000** assumes sample size of 250 claims (e.g., 150 statistical and 100 target claims).

Optional – consideration for 2021 or 2022

- EyeMed (self-funded vision): **Charge: $38,000** assumes sample size of 125 claims (e.g., 75 statistical and 50 target, or 105 statistical and 20 target).
- Kaiser (insured medical/Rx): **Charge: $55,000** assumes sample size of 200 claims (e.g., 150 statistical and 50 target). Since the Kaiser HMO plan is fully insured, the audit would be more procedural, to ensure adjudication according to contract/benefit plan intent, applying the correct cost share, following the plan document, meeting performance standards, etc. *(There are currently no audit dates available for 2021. This audit will have to be pushed to 2022)*