School District of
OSCEOLA COUNTY
FLORIDA

The School District of Osceola County, Florida Health Services Plan Assessment

October 19, 2021

RSM

School District of OSCEOLA COUNTY FLORIDA

TABLE OF CONTENTS

School District of OSCEOLA COUNTY FLORIDA

TRANSMITTAL LETTER

October 19, 2021

The School District of Osceola County, Florida
817 Bill Beck Blvd.
Kissimmee, FL 34744

Pursuant to the School District of Osceola County, Florida ("District") approved audit plan for fiscal year ("FY") 2020-21, we hereby present our report on the Health Plan Assessment. We will be presenting this report at the next scheduled Audit Advisory Committee meeting on October 26, 2021.

This assessment was requested by the School Board and approved by the Audit Advisory Committee in order for the District to better understand its new responsibilities, risks and challenges in its role as plan sponsor and administrator of the Health Plan. This assessment was designed to assist the District with this matter as governance of the District's Health Plan continues to mature.

Our report is organized in the following sections:

Executive Summary	This provides a high-level overview and summary of the observations noted in this assessment.
Background	This provides an overview of the transition to the new Health Plan structure, as well as relevant background information.
Objectives and Approach	The objectives of this assessment are expanded upon in this section, as well as the various phases of our approach.
Observation Matrix	This section includes a description of the observations noted during this assessment and recommended actions, as well as Management's response including the responsible party, and estimated completion date.
Appendix	This section provides supplementary information related to the Health Plan.

We would like to thank the staff and all those involved in assisting our firm with this assessment.

Respectfully Submitted,

RSM US LLP

RSM US LLP

EXECUTIVE SUMMARY

Background

This assessment was requested by the School Board and approved by the Audit Advisory Committee in order for the District to better understand its new responsibilities, risks and challenges in its role as plan sponsor and administrator of the Health Plan. This assessment was designed to assist the District with this matter as governance of the District's Health Plan continues to mature.

Objectives and Scope

The primary objective of the engagement was to review and assess the internal control's structure designed by the District to mitigate risks associated with its governance of the Health Plan and identify gaps. Our procedures consisted of the following:

- Obtained an understanding of the design of the Health Plan and the administrative responsibilities the District has to govern it;
- Obtained an understanding of the role and responsibility each vendor has within the Health Plan along with the District's responsibility for monitoring and oversight of this activity;
- Conducted interviews with key District personnel and vendor representatives to further our understanding of relevant operating policies and procedures and risks;
- Identified gaps and recommended opportunities for improvement.

Our fieldwork was performed during January 2021 through July 2021. We summarized and reviewed the results with appropriate members of Management, General Counsel, the Superintendent and will present to School Board and the Audit Committee.

Overall Summary / Highlights

The observations identified during our assessment are detailed within the pages that follow, along with management's action plans, responsible parties, and estimated completion dates.

Results Overview

We reviewed and assessed the internal control's structure designed by the District to mitigate risks associated with its governance of the Health Plan. In order to identify gaps, we focused on the three major components that are needed to operate the Plan: (1) the eligibility determination and processing, (2) the delivery and processing of medical benefits, and (3) the delivery and processing of pharmacy benefits.

To assist the District in its efforts to continue to mature the sophistication of its Health Plan governance, the following table depicts each individual observation, including risk category and recommended action timeline:

Summary of Observations

Observation	Risk Category	Recommended Action Within
1. Plan Sponsor Responsibilities	Compliance	3-6 Months
2. Plan Administrator Responsibilities	Compliance	3-6 Months
3. Employer and Plan Sponsor – HIPAA Privacy and Security Rules	Compliance	3-6 Months
4. Financial Reporting and Data Analysis	Operational	6-9 Months
5. Claim Administration – User Controls	Operational	3-6 Months
6. Provider Network	Operational	3-6 Months
7. Cost Containment	Operational	3-9 Months
8. Business Continuity Plan	Operational	6 Months – 1 Year
9. Customer Service	Operational	3-9 Months
10. Management and Oversight	Vendor	3 Months – 1 Year
11. Performance Guarantees	Vendor	6-9 Months

We would like to thank all District team members and health plan vendor personnel who assisted us throughout this review.

EXECUTIVE SUMMARY – CONTINUED

Summary of Key Recommendations

The following table identifies the addressable items contained within each of the individual observations and our assessment of its relative importance to the overall results.

Summary of Recommendations			
No.	**Observation**	**Description**	**Priority Ranking**
1	1-1	Obtain Independent Advice on Specialized Plan Related Matters	1
2	2-1	Creation of a Plan Administration Manual	1
3	2-2	Creation of Administrative Policies and Procedural Manual	1
4	3-1	Formalize HIPAA Compliance Solution	1
5	5-1	Perform User Control Assessment	1
6	5-2	Design of User Controls	1
7	5-3	Document User Controls in the Administrative Manual	1
8	6-1	Enhance Policies and Procedures Related to Provider Network Directory	1
9	7-1	Review and Assess the Cost Containment Strategy of the Plan	1
10	9-1	Enhance Policies and Procedures Related to Customer Service	1
11	10-1	Formalize the Management and Oversight Strategy	1
12	4-1	Perform Financial Reporting Needs Assessment	2
13	4-2	Enhance Standard Financial Reporting Package	2
14	7-2	Perform an Assessment of the Payment Integrity Process of the TPA and PBM	2
15	9-2	Evaluate Adequacy of Vendor Performance Guarantees Related to Customer Service	2
16	9-3	Evaluate Adequacy of Vendor Reporting Related to Customer Service	2
17	11-1	Review Contracts for Key Vendors to Identify Critical Areas of Performance in Order to Create and Implement PGs	2
18	8-1	Create Business Continuity Plan – Perform Training and Testing	3
19	10-2	Perform Routine Evaluations of Key Vendors	3

BACKGROUND

Overview

Healthcare costs in the United States are at an all-time high. National health expenditures are projected to grow 1.1 percentage points faster than Gross Domestic Product (GDP) per year on average over 2019-2028 (Source: CMS National Health Expenditure Fact Sheet, Last Modified December 16, 2020). With seemingly no end in sight, employers and individuals are continually looking for ways to reduce the rising costs and maintain affordability. The District's 2021 Health Plan's 2021 cost trend rate, which is an estimate of the cost increase over time, as provided to us by the Plan's actuary was projected to be 6 percent. This projection is 1.6 percent higher than the 4.4 percent that employers expect for 2021, based on Mercer's National Survey of Employer-Sponsored Health Plans 2020. As the cost of the District's health care continues to outpace GDP and the industry, there will be less money for the District to pay for other priorities.

Preparing for the Challenge

With spending levels reaching unsustainable highs, the School Board and District leadership began exploring options to reduce costs. After much analysis and deliberation, in 2019, the School Board retained the services of ProvInsure to consult and advise the School Board on the factors contributing to their increased healthcare costs.

After completing their analysis, the consultants reported that the unsustainable healthcare trend of the Plan was primarily attributed to a higher rate of chronic healthcare conditions; upsurge in disease prevalence and incidence; increased medical service utilization; escalating service price and intensity; and higher costs of new medicines, complex procedures, and technologies. The consultants also indicated the problems facing the Plan and the key drivers of its trend are not unique. However, with rapid changes in technology, new opportunities are being created by innovative vendors to solve long-standing problems like these in more efficient and effective ways.

The consultants believed that by implementing a comprehensive strategy that includes, at its core, a tiered benefit structure with member incentives; pricing transparency; programs to manage prescription drug costs; an integrated health center; programs to manage chronic health conditions; member resources; and best-in-class vendors with fee-based arrangements, the District could more effectively manage its health plan cost trend moving forward.

However, the self-funded arrangement the School Board had with its national insurance carrier at the time, limited its ability to take advantage of many of these opportunities because a national insurance carrier's turnkey approach does not permit the School Board to go outside its current service offerings to implement these options. Therefore, in order to gain more control over the Plan, the School Board chose to move away from the bundled approach offered by its carrier and adopt an unbundled approach. This required the School Board to build its own healthcare ecosystem by hiring individual vendors to operate and administer key functions within the Health Plan.

The consultants advised the School Board that leaving the existing arrangement and creating its own Healthcare Ecosystem would present its own risks and challenges to the Plan that will need to be mitigated and addressed.

Moving Forward

Taking the advice of ProvInsure, in early 2020, with the help of its advisors, the School Board began establishing the foundation of the Healthcare Ecosystem. Upon the expiration of its contract, the District elected not to renew its agreement with its national insurance company on October 1, 2020 and began operating under this new model.

The District provided health benefits to

88%

of employees through the Health Plan and paid between **75 to 86 percent** of the total average cost for covered benefits

Total Health Plan Costs to the District

$60.1M

or $8,150 per employee, representing **10.5 percent** of the District's overall operating budget

2021 Health Plan cost trend rate projected to be

6%

which is an estimate of the cost increase over time, as provided to by the Plan's actuary

OBJECTIVE AND APPROACH

Objective

This assessment was requested by the School Board and approved by the Audit Advisory Committee in order for the District to understand its new responsibilities, risks and challenges in its role as plan sponsor and administrator of the Health Plan. This assessment was designed to assist the District with this matter as governance of the District's Health Plan continues to mature. The primary objective of the engagement was to review and assess the internal control's structure designed by the District to mitigate risks associated with its governance of the Health Plan and identify gaps.

Approach

Our approach consisted of the following:

- Obtained an understanding of the design of the Health Plan and the responsibilities the District has to govern and administer it.
- Obtained an understanding of the role and responsibility each vendor has within the Health Plan along with the District's responsibility for monitoring and oversight of this activity.
- Reviewed the risk management strategy that the District prepared to identify and manage the risks associated with its administration of the Health Plan.
- Reviewed relevant documentation, including operating policies and procedures, provided by the District which depict the design of the Health Plan and the vendors contained within it.
- Conducted interviews with key District personnel to confirm and further our understanding of the design of the Health Services Plan and the monitoring and oversight of the vendors.
- Conducted interviews with representatives of the vendors, who the District identified were part of the Health Plan, to confirm and further our understanding of the relevant operating practices in place.
- Developed process maps based on our understanding of key processes as outlined and confirmed with District and vendor representatives.
- Identified the risks associated with the District's governance and administrative responsibilities of the Health Plan and key internal controls to mitigate each risk.
- Identified gaps and recommended opportunities for improvement.

Reporting

We summarized and reviewed the results of this assessment with appropriate members of District Management, the CFO, General Counsel, and the Superintendent and will present to the Audit Advisory Committee at the next scheduled meeting.

OBSERVATION MATRIX

Observation	1. Plan Sponsor Responsibilities
Description	A plan sponsor of a Group Health Plan is an organization that establishes a plan for the benefit of the organization's employees. The plan sponsor is responsible for all stages of the design, implementation, amendment, and termination of a plan. In this role, the plan sponsor ensures the plan is designed and operating in compliance with applicable laws and regulations as well as in compliance with the plan document. A plan sponsor may select a plan administrator to run the day-to-day operations of its plan. In the case of the District, it is both the Plan Sponsor as well as the Plan Administrator of the Health Services Plan. As the Plan Administrator, the District has outsourced much of the day-to-day operations of the Plan to third party vendors but continues to be the named fiduciary. A plan sponsor provides a plan with a sound governance structure, fiduciary and strategic oversight and direction. The plan sponsor protects and maintains the financial integrity and solvency of a plan, ensures applicable legal requirements are being met, and establishes procedures to safeguard a plan from fraud and unnecessary as well as unforeseen risk. To be effective in this capacity, the plan sponsor should meet regularly to oversee the operations of a plan and be comprised of individuals who possess sufficient knowledge and skills to carry out these responsibilities. Plan sponsors often hire independent advisors to fill knowledge gaps to assist them. Typical advisors may include an attorney, plan actuary, benefit consultant, and accountant. Plan sponsors will often also establish independent advisors to advise it on unique areas where deep specialization is necessary. Collectively, the independent advisors would advise the School Board on benefits, financial, and compliance matters. Although we believe the Plan Sponsor, the School Board of Osceola County, is established and operating in an appropriate capacity, we believe the School Board would benefit from added depth and expertise to assist it with identifying and mitigating certain specialized risks that will arise during the course of executing its responsibilities.
Recommendation	Considering the recent increase in complexity of the operating structure of the Plan, we recommend the School Board seek one or more independent consultants to provide it certain specialized areas of risk where knowledge gaps exist. These areas may include benefits, financial, and compliance matters that encompass, among other concerns, the Plan operating structure, funding, trend, benefit design, as well as vendor oversight and compliance with laws and regulations. It will be important for the Plan Sponsor to maintain a high level of expertise in one or more of these areas in order to successfully execute plan sponsor responsibilities.

No.	Description	Rating
1-1	Obtain Independent Advice on Specialized Plan Related Matters	1

Recommended Action Within: 3–6 Months

OBSERVATION MATRIX – CONTINUED

Observation	1. Plan Sponsor Responsibilities – continued
Management Action Plan	**Response:** Management agrees that this operating structure requires additional expertise to properly advise on our health service plan. We will obtain independent advice on specialized plan related matters, as needed. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** March 2022

OBSERVATION MATRIX – CONTINUED

Observation	2. Plan Administrator Responsibilities
Description	A plan administrator of a Group Health Plan is responsible for administering a Plan and managing its assets. In order to properly manage the day-to-day operations of a Plan and satisfy its fiduciary responsibility, a plan administrator should have a clear understanding of the laws and regulations a Plan is required to adhere to and document that understanding in a Plan Administration Manual. As the plan fiduciary, the District has the responsibility to act solely in the interest of Plan participants and their beneficiaries with the exclusive purpose of providing benefits to them. These responsibilities include carrying out their duties prudently, following the Plan document, holding Plan assets in trust and paying only reasonable plan expenses. The Plan Administration Manual should adequately address all of these responsibilities and should be reviewed periodically by someone with sufficient knowledge and understanding of these laws, regulations, and corresponding responsibilities to ensure the manual is complete and accurate. Since plan administrators generally use an internal administrative committee, the human resources department and third-party vendors to manage some or all of the day-to-day operations of the Plan, it is important for the manual to contain a matrix that defines what party (i.e., plan administrator, internal administrative committee, human resource department or third-party vendor) is primarily responsible for each compliance area. The policies and procedures relating to how compliance will be achieved, including delegating that compliance area to an outside party, should be documented in an Administrative Policies and Procedures Manual. Although the District has consulted with legal counsel to identify relevant laws and regulations pertaining to Plan Administrators requirements, these responsibilities have not yet been formally documented through a Plan Administration Manual. Administrative Policies and Procedures are designed to clearly articulate the laws, regulations, and the responsibilities it, as the Plan Administrator, is required to adhere to as well as the policies and procedures it has implemented to achieve compliance. Without a documented comprehensive understanding of the laws and regulations, written policies and procedures, and outsourcing matrix, the District may be unable to further enhance internal compliance in regard to all regulatory and operational responsibilities of administering the Health Plan. Our evaluation in this area included a cursory review of certain aspects of key laws and regulations that we believe provide measurable risk to the District. This review was not conducted to determine if the Plan is in compliance with any of these laws or regulations but to determine if they had been considered. The laws and regulations captured in our review included Patient Protection and Affordable Care Act, Mental Health Parity and Addiction Equity Act, the Health Insurance Portability and Accountability Act, the Consolidated Omnibus Budget Reconciliation Act, and Genetic Information Nondiscrimination Act. Although we found that these laws and regulations have been considered by the Plan, we do have an observation concerning the Health Insurance Portability and Accountability Act as it relates to the District in its role as employer and Plan Sponsor. The write up of this observation is located under the caption **Employer and Plan Sponsor – HIPAA Privacy and Security Rules**.
Recommendation	We recommend the District, with the help of legal counsel, create a Plan Administrative Manual that provides a clear understanding of the state and federal laws and regulations the Plan Administrator, in its role as fiduciary, is required to adhere to (e.g., Patient Protection and Affordable Care Act, Mental Health Parity and Addiction Equity Act, the Health Insurance Portability and Accountability Act, the Consolidated Omnibus Budget Reconciliation Act, and Genetic Information Nondiscrimination Act). We further recommend that the District create a matrix that defines what party is primarily responsible for each compliance area. An Administrative Policies and Procedures Manual should be written to address the areas that the District will have primary ownership. The District should undertake a review of the contracts of each of the third-party vendors who have ownership of one or more compliance areas to ensure those areas are adequately addressed in the contract. Any disconnect between the third-party vendor and its compliance responsibilities that are identified in this process should be rectified through an amendment of its contract. The oversight and monitoring of the vendors' compliance should also be documented in the District's Vendor Monitoring and Oversight Policy. (See Finding No. 10.)

OBSERVATION MATRIX – CONTINUED

<table>
<tr><th>Observation</th><th>2. Plan Administrator Responsibilities – continued</th></tr>
<tr><td>Recommendation</td><td>Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.
<table>
<tr><th>No.</th><th>Description</th><th>Rating</th></tr>
<tr><td>2-1</td><td>Creation of Plan Administration Manual</td><td>1</td></tr>
<tr><td>2-2</td><td>Creation of Administrative Policies and Procedural Manual</td><td>1</td></tr>
</table>
Recommended Action Within: 3–6 Months</td></tr>
<tr><td>Management Action Plan</td><td>Response: Management will contract with experts in the field to assist in creation of both a plan administration manual and an administrative policies and procedures manual. The existing Summary Plan Document may be modified to address any missing element addressed in the audit.
Responsible Party: Lauren Haddox, Director of Risk & Benefits Management
Estimated Completion Date: October 2022</td></tr>
</table>

OBSERVATION MATRIX – CONTINUED

Observation	3. Employer and Plan Sponsor – HIPAA Privacy and Security Rules
Description	The HIPAA Privacy and Security Rules are complex and place certain restrictions on the circumstances under which a group health plan may allow a plan sponsor access to PHI. The District has designated the Director of Risk and Benefits Management as the Privacy Officer of the Plan to design and implement policies and procedures to ensure that the Plan and the Plan Sponsor adhere to the applicable provisions of HIPAA. The Plan Document and related Summary Plan Description outlines the following obligations that the Plan Sponsor agreed to comply with that would allow the third-party administrator the ability to disclose PHI and Electronic PHI (ePHI) in compliance with HIPAA. ***Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes*** In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to: 1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards). 2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI. 3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations. 4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions. 5. Not use or disclose genetic information for underwriting purposes. 6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware. 7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524). 8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526). 9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq). 10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

OBSERVATION MATRIX – CONTINUED

Observation	3. Employer and Plan Sponsor – HIPAA Privacy and Security Rules – continued
Description	***Disclosure of Electronic PHI (ePHI) to Plan Sponsor for Plan Administration Purposes*** To enable the Plan Sponsor to receive and use ePHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to: 1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan. 2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures. 3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides ePHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware. 4. Report to the Plan any security incident of which it becomes aware. 5. Establish safeguards for information, including security systems for data processing and storage. 6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards. 7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows: a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the ePHI to be disclosed: • Privacy Officer • Director of Employee Benefits • Employee Benefits Department Employees • Information Technology Department Employees b. The access to and use of ePHI by individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan. We discussed each of the aforementioned requirements with the Director of Risk and Benefits Management and noted that the District in its role as Plan Sponsor has access to and receives PHI and ePHI to administer the Plan. The District does have district-wide security and privacy procedures in place. However, the District does not have comprehensive policies and procedures to address many of its HIPAA-specific responsibilities outlined above.
Recommendation	We recommend the District consider engaging a third-party to assist it with enhancing the District's HIPAA compliance. The solution should be flexible and scalable so that the District can formalize policies, procedures, and technologies that are appropriate for the size, organizational structure and risk to PHI and ePHI. This will require the District to have written Privacy and Security Policies; a HIPAA Privacy and Security Officer; Security Safeguards (i.e., Administrative, Physical and Technical Safeguards); Regular Risk Assessments and Self-Audits; Training; Business Associate Agreements; and Breach Notification Protocols.

OBSERVATION MATRIX – CONTINUED

Observation	3. Employer and Plan Sponsor – HIPAA Privacy and Security Rules – continued
Recommendation	Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
3-1	Formalize HIPAA Compliance Solution	1

Recommended Action Within: 3–6 Months

Management Action Plan	**Response:** Management will engage a third-party to formalize and enhance HIPAA training and compliance. The district currently utilizes HIPAA Now for its policy creation and training but will engage HIPAATraining.com to provide a more robust HIPAA compliance program that includes training certification. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** January 2022

OBSERVATION MATRIX – CONTINUED

Observation	4. Financial Reporting and Data Analysis
Description	As Plan Sponsor and Plan Administrator, the District should produce and receive a variety of financial and non-financial reporting. This information needs to be accurate, timely, in context, and appropriate in order to properly manage the plan. Reporting will come from many sources (e.g., accountant, actuary, third party administrator and pharmacy benefit manager) so compiling this information into a concise reporting package is often difficult. Some of the information that should be in the reporting package includes: • **Financial Reports** – Financial reporting should be compiled in sufficient detail so that the District can determine the financial position and results of operations of the Plan. The data provided needs to be in sufficient detail to support tracking and measuring of KPIs. Monthly cash basis balance sheet and income statement reporting with comparable numbers to prior periods and budgets is required. Additional plan demographics will also be helpful to interpret the information presented, and significant variances should be explained. At least annually, an accrual basis balance sheet and income statement should be provided in the format described above. If accruals are significant, the District should consider obtaining this information quarterly. • **Overpayment Recovery Identification and Reporting** – The post-payment integrity process of a third-party administrator should result in a significant amount of overpayment recoveries. In our experience, recoveries average 1-1½ percent of the total paid claims for the period. This reporting allows the Plan to track the identification and recovery of overpayments but also serves to identify where overpayments are taking place, which is a tool that the plan administrator can use to assist it with its oversight responsibility. • **Funding Reports** – Ensuring the plan has adequate funds to pay current and future benefits is essential to the District's responsibilities. Monitoring funding on a monthly basis allows the plan sponsor to make slight funding changes in the future, as deemed necessary, and mitigate the risk of significant unexpected fluctuations in funding obligations. • **Trend Reporting** – The plan's healthcare trend is important for the District to understand and monitor in order to project the short-term and long-term funding needs. It is a critical component of the funding report. • **Performance Guarantee Reporting** – Performance guarantee reporting should be provided to the District no less than quarterly. It is a useful tool to monitor the performance of the vendors against the contractual standards and expectations established by the plan. It will alert the District to substandard performance so that it may react in a timely manner. • **Data Analysis** – Standard data analytics and KPI reporting will be necessary to meet the District's objectives. These reports vary and are specific to the objectives of the District (e.g., provider network assessment, utilization reviews, monitoring of high-cost claimants with chronic healthcare conditions, wellness program effectiveness). Some reports will be standard monthly reports, while others may be ad hoc in nature. A recent example of a relevant ad hoc report would include reporting around the pandemic and its impact to the plan. We met with representatives of the District and many of the vendors to discuss the reporting package to monitor the plan and while there is limited regular reporting, many of the reports described above were not provided. As the District continues to enhance its monitoring and oversight of third-party vendors, these reports will be important to obtain and review.
Recommendation	As the District continues to enhance its monitoring and oversight of its third-party vendors and overall Health Plan, we recommend that it also review the reporting package prepared on a monthly, quarterly, and annual basis to determine what reporting should be provided to satisfy the objectives. All reports that are required to satisfy these objectives should be identified and requested from the vendor responsible for maintaining and reporting that data.

OBSERVATION MATRIX – CONTINUED

Observation	4. Financial Reporting and Data Analysis – continued
Recommendation	Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
4-1	Perform Financial Reporting Needs Assessment	2
4-2	Enhance Standard Financial Reporting Package	2

Recommended Action Within: 6-9 Months

Management Action Plan	**Response:** Management will work with our advisors and vendors to enhance the current monthly reporting package to include more robust, comprehensive data in order to optimally manage the finances and operations of our health services plan. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** June 2022

OBSERVATION MATRIX – CONTINUED

Observation	5. Claims Administration: User Controls
Description	Third-party administrators and pharmacy benefit managers, like those retained by the District, design systems and controls to process claims for self-insured plans. However, it is not feasible for these vendors to solely rely on their own internal control structure to ensure complete, accurate, and timely claims processing. There are certain expectations of the user organization (i.e., in this case the District); these expectations are called User Organization Controls. The controls vary depending on the design of the vendor's claims processes and procedures. The following list contains examples of controls that are generally expected for the user organization to have in place: 1. Controls should be established so that new plan details or changes to existing plans are authorized and reviewed. This plan information should be submitted accurately and on a timely basis. 2. Controls should be established to review the source document for benefit administration for completeness and accuracy and to ensure that exceptions are investigated and resolved. 3. Controls should be established so that erroneous plan or enrollment data (both sent to and received from third-party vendors) is corrected and resubmitted on a timely basis. 4. Controls should be established to determine if enrollment information and claims pricing services provided by third-party vendors are complete and accurate. 5. Controls should be established so that changes to enrollment are authorized and reviewed. The enrollment information should be submitted to the third-party vendors timely and in a complete and accurate manner. 6. Controls should be established to ensure that member accumulators are shared timely and in a complete and accurate manner. 7. Controls are in place to ensure the formularies are reviewed timely and are complete, accurate, and authorized. 8. Controls should be established to monitor and review claims detail, fund requests, and receipt and funds summary reports for completeness, accuracy and duplicate payments, as well as to ensure that exceptions are investigated and resolved in a timely manner. 9. Controls are in place to ensure that client specific systems are tested prior to processing claims in a production environment. 10. Controls are in place to ensure exception reporting is responded to in a timely, accurate, complete manner and is authorized. 11. Controls are in place to ensure third party vendor contracts are executed in a complete and timely manner to ensure changes in terms and conditions are loaded timely. The third-party administrator and pharmacy benefit manager (the entities responsible for processing claims for the District) do not have service organization controls (SOC) reports. Therefore, we were unable to establish the expectations of these vendors. Although the District reported performing or outsourcing to its consultants many of the activities described above, none of the User Controls are formally documented.
Recommendation	To mitigate the risk of untimely, inaccurate, or incomplete claims processing, we recommend the District contact the third-party administrator and pharmacy benefit manager to determine what User Controls are required so that these controls may be formalized, documented, and implemented. Once implemented, these controls should be tested for operating effectiveness and results provided to the District for review.

OBSERVATION MATRIX – CONTINUED

Observation	5. Claims Administration: User Controls – continued
Recommendation	Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
5-1	Perform User Control Assessment	1
5-2	Design of User Controls	1
5-3	Document User Controls in the Administrative Manual	1

Recommended Action Within: 3–6 Months

Management Action Plan	**Response:** Management will continue to enhance the design and documentation of user controls. Our TPA and PBM currently do not have service organization controls (SOC) reports; however, the district's external financial auditors are conducting additional control testing. Going forward, the district will require the TPA and PBM to provide SOC reports to document effective user controls. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** September 2022

OBSERVATION MATRIX – CONTINUED

Observation	6. Provider Network
Description	A health plan is only as strong as its provider network. The provider network should consist of an adequate service area containing quality providers and facilities capable of administering the full spectrum of covered health and welfare services (i.e., provider and facility specialty types consistent with certain time and distance standards). The network should be sufficient to provide plan participants with health care services without placing undue burden on those seeking covered services. The adequacy of the provider network should be continuously monitored by the plan sponsor, or its designated vendor, on a regular basis. Typically, this is performed annually if the network has not been fully established and no less than triennially thereafter. The District utilizes a health center to provide various services typically administered by a primary care physician or an urgent care center, as well as a provider network established by Evolutions Healthcare Systems, to ensure its participants can receive covered health and welfare services offered by the Plan. To effectively evaluate the service area and the adequacy of the providers and facilities within the service area, the District and its advisors should have access to a complete and accurate provider directory relative to its network. Through its oversight activities, the District has identified concerns with the accuracy and timeliness of the maintenance of the provider directory by Evolutions Healthcare Systems and have been working with this vendor to address these concerns. The provider directory is a necessary tool to evaluate a provider network. It is also critical for the Plan's participants to obtain covered services from the most qualified providers, and to allow providers enough information to render a referral for specialty services or other necessary treatment.
Recommendation	We recommend the District continue to work with Evolutions Healthcare Systems to bring the provider directory up-to-date and establish additional monitoring policies and procedures to ensure it is kept up to date. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report. **No.** | **Description** | **Rating** 6-1 | Enhance Policies and Procedures Regarding Provider Network Directory | 1 **Recommended Action Within:** 3–6 Months
Management Action Plan	**Response:** Management will develop monitoring procedures and continue to work with Evolutions to timely update and enhance the online directory and make it more user-friendly. Evolutions is currently finalizing expanding urgent care needs across Florida in particular areas near college campuses. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** January 2022

OBSERVATION MATRIX – CONTINUED

Observation	7. Cost Containment
Description	A strong, cohesive cost containment strategy is critical to an efficient and cost-effective plan. There are many aspects to a cost containment strategy, as well as service providers that offer solutions that a plan must consider in order to ensure that the strategy is comprehensive and complete. In addition to hiring vendors to handle specific aspects of the cost containment strategy, the plan should look to its third-party administrator and pharmacy benefits manager to have rigorous cost containment processes built into its systems. A thorough assessment of the ecosystem is necessary to ensure the strategy is executed properly and working effectively. Although the District has implemented many cost containment solutions throughout the healthcare ecosystem, our review identified opportunities to enhance the current process specific to transplant negotiations and surgery networks. (Surgery networks would encompass facility, physician, anesthesia and other ancillary services.) We also identified opportunities in the payment integrity process of the third-party administrator. With respect to the third-party administrator, our observations encompass both the prepayment and post-payment activities including, but not limited to: clinical edits; fraud, waste and abuse edits; hospital bill audits; and duplicate claims reviews.
Recommendation	As the District continues to build out its cost containment strategy, we recommend the District meet with its advisors, third-party administrator and prescription benefit manager to review its strategy to design a complete and comprehensive approach. We further recommend that the District implement formal cost containment reporting requirements to independently review and monitor the operating effectiveness of initiatives. Reporting should be performed on a periodic basis to maximize cost avoidance and savings opportunities. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
7-1	Review and Assess the Cost Containment Strategy of the Plan	1
7-2	Perform an Assessment of the Payment Integrity Process of the Third-Party Administrator and Prescription Benefit Manager	2

Recommended Action Within: 3–9 Months

Management Action Plan	**Response:** Management will formalize our cost containment strategy. The district contracts with Milliman SkySail to monitor contract compliance as related to our Pharmacy Benefit Manager. The district will contract for an annual comprehensive claims audit of our Third-Party Administrator. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** June 30, 2022

OBSERVATION MATRIX – CONTINUED

Observation	8. Business Continuity Plan
Description	The operations and administration of the District's health plan is susceptible to many adverse circumstances including, but not limited to, weather-related emergencies, data loss or data breaches. These threats pose a significant threat to the District's ability to maintain a fully functional health services plan in the event plan operations or data is compromised. A business continuity plan is designed to reduce the financial or medical impact, limit downtime and maximize efficiency. To promote a successful recovery plan, it is imperative to have buy-in from the plan administration team, senior management, and contracted vendors. Business continuity planning is not only necessary to comply with laws or regulations, but also to protect patients and employees, deliver the best patient care, reduce financial impact and preserve reputation. Many adverse circumstances exist which could pose a threat to the operational effectiveness of the Health Plan. The District can manage the Plan's ability to continue providing quality care through effective business continuity planning. Currently, the District does not maintain a formal business continuity plan designed to protect patient data in the event of an adverse circumstance. As a result, limited mitigation procedures exist to outline the strategies for managing disruption to key infrastructures, such as networks, communications, and file archives. Without developing disruption alternatives, the District risks non-compliance with obligations under healthcare privacy laws, the inability to recover plan data, or maintain health plan operations.
Recommendation	We recommend the District continue developing and maintaining a business continuity plan. To effectively respond to an adverse event, a unified recovery process should exist to protect critical patient data and systems. Procedures should be in place, prior to an event, which identify critical processes and data. Mitigation measures should be developed, as well as response and recovery actions that enable a quick recovery. Essential components of disaster recovery in healthcare can include, but are not limited to, network security/redundancy, data backup solutions, and redundant telecommunications lines. Additionally, we recommend the District consider implementing the following preventative measures to enhance the business continuity plan mitigation strategy: cybersecurity training for personnel; disaster recovery testing and drills; ongoing network penetration tests; and test recoveries of data backups. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
8-1	Create Business Continuity Plan – Perform Training and Testing	3

Recommended Action Within: 6 Months – 1 Year

OBSERVATION MATRIX – CONTINUED

Observation	8. Business Continuity Plan – continued
Management Action Plan	**Response:** Management will enhance our current district business continuity plan to incorporate the health services plan, review our partner's business continuity plans annually, and monitor performance accordingly. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** June 30, 2023

OBSERVATION MATRIX – CONTINUED

Observation	9. Customer Service
Description	A plan sponsor is responsible for ensuring the accessibility of quality customer service for plan participants. Since plan sponsors generally use an internal administrative committee, the human resources department, and third-party vendors to manage some or all of the customer service components, it is important to have a comprehensive documented understanding of the processes and procedures related to providing, managing, and outsourcing the respective customer service functions. The document should clearly define roles and responsibilities both internally and with vendors. Agreements with vendors providing customer service should contain performance guarantees that hold the third party responsible for agreed upon metrics that measure service quality. Metrics may include requirements around timeliness and accuracy of response; timeliness of resolution; abandonment rates; and customer satisfaction surveys. The District's current monitoring of customer service relies on tracking formal complaints from plan participants. If an end user has an issue with a service provider, they have the option to file a formal complaint with the District, who would then notify the vendor seeking a resolution within a given timeline. Although the District tracks complaints and meets with vendors as needed to discuss customer service issues, we believe a standardized customer service strategy, including performance guarantees and reporting, would enhance its ability to monitor the quality of customer service provided to Plan participants. This reporting would also be useful to identify trends in order to move the District's oversight from reactive to proactive.
Recommendation	We recommend the District enhance and formalize its customer service strategy and procedures, and ensure that strong performance guarantees, as outlined in the Performance Guarantee Observation, are included in all agreements with vendors providing customer service to plan participants. Service agreements with vendors should also include required reporting on the performance metrics, so that the District may collect and assess trends in customer service quality. The long-term impact of trend analysis is higher quality customer service that mitigates the risk of member disruption due to abandonments, mishandled calls, poorly trained customer service representatives, and member confusion. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
9-1	Enhance Policies and Procedures Related to Customer Service	1
9-2	Evaluate Adequacy of Vendor Performance Guarantees Related to Customer Service	2
9-3	Evaluate Adequacy of Vendor Reporting Related to Customer Service	2

Recommended Action Within: 3–9 Months

OBSERVATION MATRIX – CONTINUED

Observation	9. Customer Service – continued
Management Action Plan	**Response:** Staff regularly emphasizes stellar customer service expectations on weekly calls. Management will formalize expectations for customer service with district staff and all contracted parties. Customer service expectations of our partners will be clarified in our contractual agreements to include performance guarantees. Legal counsel and staff have been working with contracted parties on their evaluations. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** June 2022

OBSERVATION MATRIX – CONTINUED

Observation	10. Management and Oversight
Description	Proper monitoring and oversight of a Group Health Plan requires an integrated risk management approach to mitigate significant compliance, operating, and vendor risks. This approach starts with a risk assessment to identify significant risk across the health plan and assesses the risk to determine what action is required by a plan sponsor. The risk assessment process considers the operating environment of the plan and its vendors as well as how outside forces such as providers, employees, and carve-out vendors exert pressure. Risks are then evaluated individually as well as collectively to determine the proper response. Given the potential for significant financial loss, plan sponsors generally undertake continual monitoring and oversight to manage these risks. Plan sponsors commonly perform compliance audits, operation audits, performance guarantee audits, focused claims audits, rebate audits, and statistical claims audits to oversee the administration of a plan. Focused claims audits are also used by plan sponsors to address specific risks that reside within the claim cycle. Dependent eligibility audits are commonly used by plan sponsors to oversee the eligibility process. The frequency and type of audits that a plan sponsor may utilize varies based on the risks that are present in a plan. Although the District has conducted some of these audits in the past, it does not have a formal process to manage and oversee its vendors.
Recommendation	We recommend the District create a formal process to continue managing and overseeing it vendors through the utilization of an integrated risk management approach. The process should be well defined and include routine monitoring and oversight of its vendors. The process should commence with an annual risk assessment to determine what risks are appropriate to mitigate. Reviews of performance guarantee reporting, exception reporting, and overpayment recovery reporting should be performed monthly. Routine meetings with the vendors that cover areas of concern that the District identifies with these and other monitoring activities it performs should be discussed on those calls. Data analytics and annual audits and review of the nature described above should be a part of this process. Other oversight activity should be added as situation's warrant. The result of this activity should be reported to the School Board no less than quarterly. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report.

No.	Description	Rating
10-1	Formalize the Management and Oversight Strategy	1
10-2	Perform Routine Evaluations of Key Vendors	3

Recommended Action Within:	3 Months – 1 Year
Management Action Plan	**Response:** We will create a formalized management process to oversee our vendors, including routine monitoring of contract terms such as performance guarantees, reporting requirements, data analysis review, and customer satisfaction. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** October, 2022

OBSERVATION MATRIX – CONTINUED

Observation	11. Performance Guarantees
Description	Well defined mutually agreed-upon contractual performance guarantees (PGs) that are tied to key performance indicators and industry best practices are an essential component of a Plan Sponsor's vendor oversight and monitoring program. When constructed properly, these guarantees serve as a road map and objective means for the Plan Sponsor and its vendor to ensure the service provider is meeting the expectations of the contract. Because each service provider function and contract will be unique, PGs need to be aligned to the services being contacted and the expectations of the Plan. As an example, key areas that are generally considered for a service provider who is responsible for processing medical claims would include one or more PGs in the following categories: Account Management, Enrollment, Claims Processing, Cost Containment, and Customer Service. The following list provides some examples of key functions that may be covered within each of these categories: 1. Account Management a. Meeting Attendance b. Standard Report Turnaround Time c. Standard Report Accuracy d. Ad Hoc Report Turnaround Time e. Data Delivery Turn-Around Time f. Account Management Satisfaction 2. Eligibility a. Timeliness of Open Enrollment Processing b. Timeliness of ID Card Distribution c. Timeliness of Processing of Eligibility File d. Timeliness of Processing Eligibility Changes e. Timeliness of Processing of Eligibility Data to Third Party Vendors 3. Claims Processing a. Financial Accuracy b. Procedural Accuracy c. Payment Accuracy d. Processing Timeliness 4. Cost Containment a. Case Management Program Outreach b. Timeliness of Processing Claims Data to Third Party Vendors

OBSERVATION MATRIX – CONTINUED

Observation	11. Performance Guarantees – continued
Description	5. Customer Service a. Average Speed to Answer b. Call Abandonment Rate c. Written Inquiry Response Time d. Email Inquiry Response Time e. First Inquiry Resolution (Call, Written, and Email) f. Member Satisfaction Since the penalties for failure to perform need to be meaningful for the PGs to be an effective tool, industry leading practice is that at least 5% of total administrative fees should be placed at risk and spread appropriately amongst all of the PGs that are implemented. Once PGs have been determined it is important to decide on the metrics that will be used and the targets to be achieved. The tools and techniques to measure and monitor these metrics will be critical to ensuring a PG will work as intended. When drafting PGs it is important to clearly define the standard to be achieved along with the measurement criteria and metrics; measurement period; fees at risk; and liquidated damages for failing to meet the standard. To mitigate the risk of ambiguity, guarantee should also contain an example of the liquidated damages calculation. Upon reviewing the service provider agreements of the Plan, we noted the contracts outlined service level expectations but do not contain specific performance guarantees.
Recommendation	We recommend that the District implement PGs for each key vendor in the healthcare ecosystem during the next round of contract negotiations or sooner if practicable. To ensure the PGs are on point, the District should evaluate each contract and identify the critical areas of performance. Once these areas have been identified, the District should, on a contract-by-contract basis, discuss its expectations with the individual vendor in order to identify the PGs that vendor already has systems in place to measure along with the metrics it uses to monitor performance. This will provide a starting point for the negotiation process. In cases where the vendor's standard guarantees do not cover an area of concern by the Plan, client specific PGs may be created. However, when creating these types of guarantees, it will be important to ensure the vendor has the system capabilities to objectively measure and monitor them. Once the PGs have been identified, the guarantee should be established at the desired level of service, which should be no less than the industry standards. Since PGs are self-monitored and reported, the District should conduct regular audits of them. Periodically, the District should review the PGs it has in place with each vendor to ensure the nature, timing and extent of the PGs are still appropriate. Addressable Item(s): The following table identifies the addressable items contained within this item number and our assessment of its relative importance based the other addressable items contained within this section of the report. **Recommended Action Within:** 6–9 Months

No.	Description	Rating
11-1	Review Contracts for Key Vendors to Identify Critical Areas of Performance in Order to Create and Implement PGs	2

OBSERVATION MATRIX – CONTINUED

Observation	11. Performance Guarantees – continued
Management Action Plan	**Response:** Management and legal counsel will amend contracts to include performance guarantees, where appropriate, and incorporate performance guarantees into any new vendor contracts. **Responsible Party:** Lauren Haddox, Director of Risk & Benefits Management **Estimated Completion Date:** October 2022

APPENDIX A – HEALTHCARE ECOSYSTEM

The Design

The School Board retained the services of ProvInsure to help it identify the key components of the healthcare ecosystem as well as to source vendors to build out the Healthcare Ecosystem. ProvInsure, was also retained to assist the District and the School Board in managing the day-to-day administrative functions, monitor plan performance, and provide comprehensive reporting. It also has the responsibility to monitor plan activity in order to identify and recommend improvement strategies aimed at enhancing the quality of care and cost savings through detailed data analytics.

The identification process commenced by mapping out the ecosystem by focusing on the three major components needed to operate the plan: (1) the eligibility determination and processing, (2) the delivery and processing of medical benefits, and (3) the delivery and processing of pharmacy benefits. The results of this process follows.

Eligibility Determination, Management and Processing

The School Board determined that an eligibility vendor was necessary to manage the eligibility process for the Plan. The vendor would be responsible for the following:

- Open enrollment
- Dependent eligibility verification and maintenance
- COBRA administration
- Collection of coordination of benefits information, Medicare and other commercial insurance
- Communication of eligibility to the carve-out vendors
- Call center for management of eligibility questions and resolution

Delivery and Processing of Medical Benefits

The School Board determined the following components were required to deliver medical benefits to the members of the Plan and process claims.

Provider Network Manager – This provider establishes and maintains a provider network for the Plan. It will also be used to manage the contracts the Plan holds with these providers, price claims incurred by eligible Plan participants for services rendered by these providers, and forwards this information to the Plan's Third Party Administrator for adjudication. It also provides provider appeals services.

Claims Re-Pricing Vendor – This vendor attempts to reduce the cost of out-of-network benefits rendered by providers who are not participating in the provider network established for eligible Plan participants. These services include re-pricing based on benchmarking data (i.e., a Medicare percentage) and patient advocacy services.

Health Center Administrator – This provider established offsite clinics (i.e., Center for Employee Health) that eligible Plan participants may access to seek cost effective services and supplies, which it manages for the Plan. Services include, but are not limited to, medical examinations, physical therapy, chiropractic care, x-rays, eye exams, occupational therapy, dietician care, and specialist diagnostics.

APPENDIX A – HEALTHCARE ECOSYSTEM – CONTINUED

The Design – continued

Diagnostic Imaging Vendor – This vendor provides complex diagnostic imaging services to the offsite clients to manage these services in a cost-effective manner. Diagnostic imaging, also called complex or medical imaging, refers to the use of certain technologies, including electromagnetic radiation, to produce images of internal structures of the body to assist in medical diagnosis.

Medical Management Vendor – This vendor provides utilization, disease, and case management. Utilization management consists of determining whether or not a Plan participant who incurred a service that submit for payment to the Plan was eligible for benefits, if the services were a covered benefit, and if the procedure was medically appropriate. Disease management involves a team of disease specialists initializing a patient specific care plan for those diagnosed with certain diseases. Case management nurses educate patients on their condition, encourage medical compliance, ensure transplant network agreements are in place for potential transplant candidates, assist with follow-up appointments and reinsurance coordination, negotiate with out-of-network providers, and coordinate cost containment for dialysis.

Medical Advocate Program – This vendor provides nurse concierge services. Plan participants who have questions regarding medical services may contact this vendor to identify the highest quality and most cost-effective provider to serve the patient's needs; assist with scheduling; address medical concerns; and offer second opinions as well as different treatment options.

Patient Portal – This vendor provides a patient portal where Plan participants have access to medical records, upcoming appointments, may request prescription refills, and utilize educational material related to general health care matters as well as plan specific guidance.

Stop Loss Carrier – This vendor provides stop loss insurance to mitigate the risk of adverse claims experience for high-cost claimants.

Third Party Administrator – This vendor provides claim adjudication services and administers the claims received from the Provider Network Manager or directly from out-of-network provider or Plan participants. This vendor is responsible for ensuring the claim is priced in accordance with Plan benefits, coordinating with carved out vendors (e.g., claims repricing vendor and medical management vendor) as well as providing certain cost containment solutions (e.g., subrogation). It also performs Provider and Member Appeals services as well as Grievance services.

Delivery and Processing of Pharmacy Benefits

The School Board determined the following components were required to deliver pharmacy benefits to the members of the Plan and process claims.

Pharmacy Benefit Manager – This vendor is responsible for network administration, prescription claims processing and payment, clinical services, formulary development and management, rebate administration, and specialty drug administration.

Specialty Pharmacy – This vendor dispenses specialty drugs to eligible participants of the Plan who have chronic and complex medical conditions.

International Drug Program Vendor – The vendor is providing mail order services for Plan participants who participate with this vendor for brand name high-cost drug obtained from another Tier I Pharmaceutical Country such as Canada, England, and New Zeeland.

Pharmacy Consultant – This vendor monitors pharmaceutical claims after they are processed by the Plan's pharmacy benefit manager. Claims data is reviewed for incomplete patient and benefit information, issues, and non-compliance. Urgent matters are immediately communicated to the District and its consultants. The compliance status and any non-urgent issues within the claims data are compiled for quarterly reporting and communicated to the District.

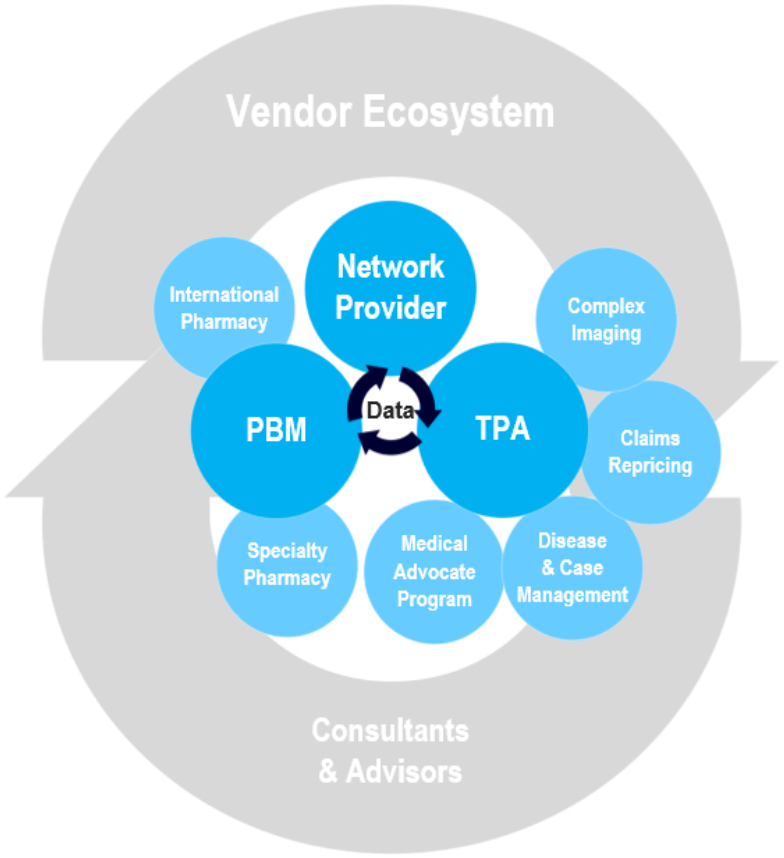
APPENDIX A – HEALTHCARE ECOSYSTEM – CONTINUED

The Healthcare Ecosystem

The following vendors provide service(s) to the District, the School Board, and the Health Services Plan:

Delivery and Processing of Medical Benefits	
Position	**Vendor**
Provider Network Manager	Evolutions Healthcare Systems
Claims Re-Pricing Vendor	Payer Compass
Health Center Administrator	RosenCare
Diagnostic Imaging Vendor	Green Imaging
Medical Management Vendor	Secure Health
Patient Portal	Healics
Stop Loss Carrier	Westport
Third Party Administrator	Aither
Nurse Concierge Services	Medical Advocate Program

Delivery and Processing of Pharmacy Benefits	
Position	**Vendor**
Pharmacy Benefit Manager	Ventegra
Specialty Pharmacy	Prescriptions Unlimited and Costco
International Drug Program Vendor	ElectRx
Pharmacy Consultant	SkySail Rx



APPENDIX B – HEALTH SERVICES PLAN SUMMARY

SDOC Health Services Plan

1. Historically, SDOC was contracted with CIGNA in an ASO role (Administrative Services Only). Gallagher was the broker/consultant. Claims trend increases were running 6%/year on average.

2. In April 2016, the district opened the Center for Employee Health. Advent Health (formerly Florida Hospital) was selected through an RFP process to manage and staff the Center.

3. In the first year of Center operations, the district was able to control claims expense and offset national trend rates. However, after year 1, we quickly began to see increases in claims expense as Florida Hospital was referring Center patients to their independent high-cost facilities.

4. For the next two years, healthcare expenses continued to skyrocket at unsustainable rates, requiring the district to supplement the health trust fund by an additional $25M over a four-year period. This prompted the School Board to consider alternative approaches to our health plan.

5. In May 2019, SDOC contracted with ProvInsure to become the broker/consultant effective June 1, 2019, and for RosenCare to take over managing the operations of the Center for Employee Health, effective October 1, 2019.

6. Immediately, ProvInsure began working with the district to implement high quality, lower cost healthcare solutions for our employees and their families.

7. Effective with the plan year beginning October 1, 2020, a new SDOC health services plan was launched which included our own custom-built network through Evolutions, consisting of direct contracts with hospitals and providers. Aither Health was selected as the TPA (Third Party Administrator) and Ventegra as the TPBM (Transparent Pharmacy Benefit Manager).

8. A new plan design structure was implemented based on tiers. Tier 1 providers are those who've contracted with our network to provide high quality healthcare at the greatest value. Tier 2 providers have also contracted directly with the SDOC network, although at slightly higher rates. Tier 3 encompasses all other providers, as no provider is considered "out of network". Employees have their choice of going anywhere they wish; however, the tiered plan design structure incentivizes using Tier 1 and Tier 2 providers based on lower or no out-of-pocket costs.

9. Since 2019, the SDOC health services plan has stopped the bleeding in our health trust fund and reversed the trend from annual cost increases to a reduction in healthcare expenses of $6M in year 1 and an additional $4M in year 2. This has allowed the district to keep operating dollars in the classroom that otherwise would have been necessary to supplement rising healthcare costs.

10. By controlling our healthcare expenses, the School Board has been able to offer salary increases to our employees this year despite the limited increase in operational funding per student. In addition, the School Board has proposed a one paycheck premium holiday for this year and next.

This document was shared at the School Board Workshop on September 7, 2021.

APPENDIX B – HEALTH SERVICES PLAN SUMMARY - CONTINUED

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FL
HEALTH AND LIFE INSURANCE TRUST FUND

Source	ACCT. NO.	2015-16 Actual	2016-17 Actual	2017-18 Actual	2018-19 Actual	2019-20 Actual	2020-21 Actual
NET POSITION AT BEGINNING OF YEAR:							
Total Beginning Net Position		$ 15,623,950	$ 15,077,118	$ 11,703,413	$ 10,521,021	$ 10,356,982	$ 10,250,945
REVENUE:							
Premiums	484						
Employer	070	43,399,239	42,926,057	44,292,617	46,419,598	49,600,530	48,615,146
Employee	071	5,810,501	5,712,148	6,158,540	7,669,189	8,429,609	7,595,789
Retiree/LOA	072	2,301,323	1,718,859	1,256,350	1,403,060	1,518,947	1,243,656
COBRA	073	46,393	53,842	69,975	102,372	75,015	46,350
Non-operating Revenue	495	97,697	52,746	66,404	86,266	74,948	89
Transfers In		3,000,000	3,000,000	8,500,000	10,500,000	-	-
Total Revenue		54,655,153	53,463,652	60,343,886	66,180,485	59,699,049	57,501,030
HEALTH & LIFE INS EXPENSES:							
Professional & Technical Services	3100	2,865,782	4,572,603	4,505,658	5,158,461	5,080,601	9,081,854
Insurance & Bond Premiums	3200	1,405,878	1,151,420	785,827	840,550	678,130	815,133
Other Purchased Services	3900	44,027	48,086	82,131	59,853	32,832	333,175
Supplies	5000	132,212	347,761	378,941	481,229	660,507	999,902
Furniture, Fixtures, & Equipment	6000	71,304	7,810	-	1,345	27,950	4,185
Dues and Fees	7300	429,095	286,919	50,871	52,403	-	44,691
Claims Expense	7700	50,245,416	50,317,692	55,616,035	59,644,352	53,216,080	44,451,805
Depreciation Expense	7800	8,271	105,066	106,815	106,331	108,986	107,861
Total Health & Life Ins Expenses		55,201,985	56,837,357	61,526,278	66,344,524	59,805,086	55,838,606
COVID Claims Offset		-	-	-	-	-	(2,765,331)
Net Health & Life Ins Expenses		55,201,985	56,837,357	61,526,278	66,344,524	59,805,086	53,073,275
NET POSITION AT END OF YEAR:							
Total Ending Net Position		$ 15,077,118	$ 11,703,413	$ 10,521,021	$ 10,356,982	$ 10,250,945	$ 14,678,700

This document was shared at the School Board Workshop on September 7, 2021

APPENDIX C – SELF-INSURED HEALTH SERVICES PLAN APPROACH

Self-Insured Health Services Plan Approach

Last year, in an effort to provide better benefits to employees at reduced costs, the District opted to discontinue a long-term ASO arrangement in favor of establishing their own plan design and approach to providing benefits. This included building out an inter-disciplinary platform comprised of best-in-class service partners to manage the various components of our program. This talented team was brought together and over the past year has become an integrated team working together to provide superior service and benefits while significantly reducing costs when compared to previous years.

There are 3 components that make our approach unique:

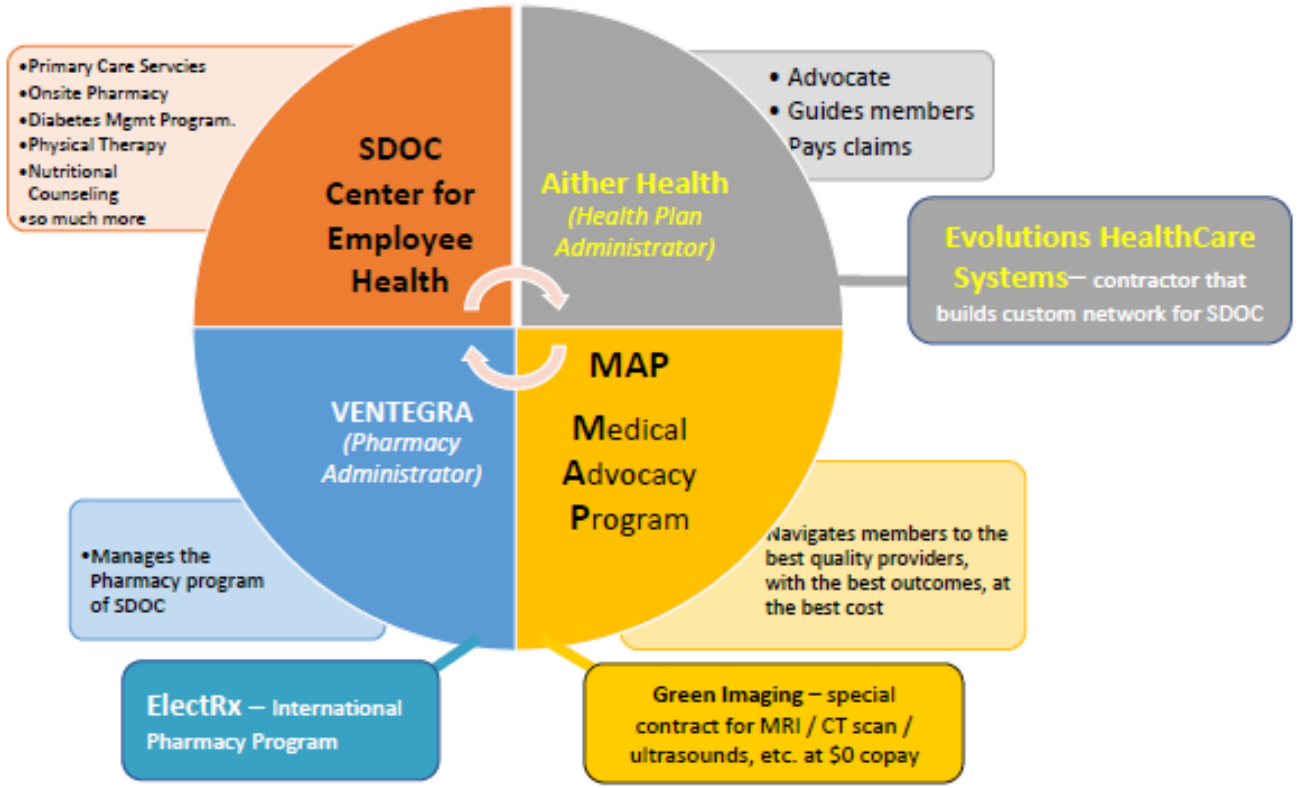
1. Overall active management by the plan sponsor. Many plan sponsors take a "passive" approach to benefits and hire an administrative partner to manage the health plan on their behalf. This is essentially a hands-off approach relying on the administrative partner to deal with the day-to-day operation of the plan. Under the SDOC self-insured health services plan model, the Director of Risk and Benefits takes a very hands-on approach and is involved on a daily basis with the management of the process. Our platform allows for the transparent flow of information to all partners, advisors and certainly, the district.

2. We have opted not to use a traditional "Network" approach managing member access to care. Under these traditional approaches, members can seek care "in-network" with reasonable copays and out-of-pocket exposure, or, if they choose a "non-participating" provider, they are exposed to substantially higher out-of-pocket expenses. Under our approach, we allow employees to seek care anywhere they choose with benefits levels only found "in-network" under traditional plans. We manage expenses at the provider level without penalizing employees for their choices. We have established a 3-tier provider panel. Tier 1 and Tier 2 providers are those with whom we have established a direct contract (through Evolutions, our provider relations partner). Tier 3 covers "all other" providers. While members seeking care at tier 3 have copays, and out of pockets as they have experienced "in-network" under previous plans in the past, providers are reimbursed using a "Reference Based" methodology. Members find lower copays and out of pockets when seeking care from Tier 2 and Tier 1 providers. At the core of our program is an SDOC owned Health Center modeled after the Rosen Medical Center and managed by RosenCare. These multi-discipline facilities (2 so far) provide a variety of free services to members choosing to avail themselves of this resource. Having already expanded access to more services, we are seeking to draw more care (including pharmacy) into this District owned facility over time. So far in our first year, 89% of all (non-Health Center) claims have been at Tier 1 or 2 levels.

   For additional plan specifics, view the Benefits Guide and SBCs at:
   https://www.osceolaschools.net/Domain/156 and http://osceolaschools.net/benefits

3. Ours is an open architecture that is constantly seeking ways to provide a higher service level to members at lower costs to the plan. We presently have a direct contract with Green Imaging of Dallas, TX providing free imaging services when employees choose to utilize their services. Our musculoskeletal partner out of the Health Center is MSK of Tallahassee. We have a nurse-concierge service through MAP (Delphi of St. Petersburg) providing guidance to higher quality, lower-cost providers and rewarding employees when making better health access decisions. We use SCM for chronic kidney disease management. We have chosen Prescriptions Unlimited, a local pharmacy partner to manage our specialty pharmacy while Elect Rx is available for international sourcing, with employees accessing free pharmacy products when utilized. We are not mired in legacy thinking and are open to other programs and resources that make sense.

APPENDIX C – SELF-INSURED HEALTH SERVICES PLAN APPROACH - CONTINUED



RSM US LLP
7351 Office Park Place
Melbourne, Florida 32940
321.751.6200
www.rsmus.com