**Gateway Fund - Bergen and Metro**

**2023 Operations Review and Medical Claims Audit**

A health care claims audit is designed to assess whether claims are being adjudicated correctly, in accordance with the provisions of the plan of benefits, and paid only on behalf of eligible participants as determined by the provisions of the plan. Best practice is to look beyond just the claims and to identify operational or administrative issues that may lead to broader claims processing and service issues, allowing for real-world recommendations for resolution.

AIM will perform an Operations Review of Aetna, which is an in-depth evaluation of the controls employed by the administrator to ensure quality administration. In conjunction with the Operations Review, a medical claims audit will also be conducted on the administration by Aetna for the HIF employee medical plan. The 2023 audits will include claims adjudication for both Bergen and Metro as claims are being processed under the same HIF but under different funding. A division of the two funds will occur January 1, 2024.

For the Operations Review (OR), a comprehensive Request for Information (RFI) is prepared and sent to Aetna in advance of the scheduled OR meeting.

* During the OR, interviews are conducted with key management and operations personnel to review Aetna’s responses, procedures and methodologies.
* The OR encompasses such areas as system capabilities, staffing levels and turnover, performance standards, quality assurance for claim processing and customer service, Aetna’s actual performance vs. client-specific and/or industry standards for accuracy, timeliness of claims adjudication, reporting capabilities, coordination with other administrative areas/vendors, and cost-management activities such as overpayment recovery, pricing controls and TPL investigations.
* Findings are compared to industry best practices.
* An OR can identify weaknesses in administrative controls that lead to poor performance.

The medical claims audit will be conducted on a sample of claims finalized during the identified audit period. The audit will assess whether claims are being adjudicated correctly, in accordance with the provisions of the HIF plan of benefits and paid on behalf of eligible participants as determined by the provisions of the plan.

The purpose of the audit is to provide an assessment of Aetna’s overall claims processing and financial accuracy performance during the audit period versus industry standards and applicable contractual standards.

Claim Audit Methodology - The principal objective of the claims audit will be to determine Aetna’s claim processing accuracy and financial accuracy on medical claims. The financial accuracy calculation will identify the financial impact (and potential recoveries) for payment errors. In addition, a critical component of the audit process will be to identify the causes of errors. AIM’s audit findings and recommendations will specifically identify these causes and recommend solutions that can help Aetna improve its claims administration and eliminate the kinds of errors identified through the audit process.