MIDDLESEX COUNTY • NJ

MIDDLESEX COUNTY JOINT HEALTH INSURANCE FUND

CLAIMS AUDIT

REQUEST FOR PROPOSAL

October, 2022

SCOPE OF SERVICES

The Middlesex County Joint Health Insurance Fund ("the Fund") is comprised of seven separate entities and covers approximately 5,000 participants. The Fund desires to have an evaluation of claim services provided by Horizon ("the Administrator"), on claims incurred during the 2021-2022 plan years. Horizon is responsible for the adjudication of claims for a self-insured POS, PPO, Traditional and OMNIA plans offered by the Middlesex County Joint Health Insurance Fund. The following is the number of participants enrolled in the self-insured Horizon plan:

Plan	Number of Employees	Claims Administration
Self-Insured Plan	2600(employees/retirees)	Horizon Blue Cross/Blue Shield of NJ

PROJECT OBJECTIVES

The objectives of this audit are to evaluate the claims Administrator against industry and contract standards for accuracy, timeliness and quality of operation and service, to recommend improvements and to identify performance issues for future contracts. The operational review will focus on operational issues, which pose potential risks to the Fund's assets through claim adjudication. A statistical claim audit will involve on-site testing of a statistically valid sample of claims at a level of accuracy consistent with industry standards. Specifically, the review should answer the following questions:

- What is the accuracy of eligibility data resident on providers' claims systems utilized to process claims?
- What is the accuracy of medical claim payments and how does that accuracy compare to internal standards, contractual guarantees and generally accepted industry standards?
- Does the claim system fully support automatic claim adjudication?
- Are claim processing duties and responsibilities appropriately segregated?
- Is claim documentation appropriately protected from loss or damage?
- Are "people, process and technology" fully integrated throughout the claim area to support and encourage accurate claim processing?
- Does the system accurately protect the confidentiality of employees in compliance with regulations?
- Is the system in compliance with the regulations applicable to TPAs of the New Jersey Department of Banking and Insurance and Department of Community Affairs?
- Does the system have the ability to track claim inquiries and correspondence?
- Are claim inquiries and appeals requests tracked appropriately and in compliance with applicable law?
- What is the average turn-around time for processing claims?

AUDIT PLAN AND APPROACH

Operational Review

The Administrator's practices and procedures will be reviewed through claim administration questionnaires, on-site visits, and interviews with the claims Administrator's personnel. The review should focus on staffing, training, policies and procedures and the handling of complicated claims.

Testing of Claims

The Proposer will review actual claim documentation and test the internal policies and procedures which direct payment of the particular transaction. The number and type of claims tested may vary based on the population, size and sampling technique selected.

The Fund also desires to audit a specific aspect of Horizon claims processing that relates to coordination of benefits with Medicare. The Fund's concerns in this area include, but are not necessarily limited to:

1. Whether Horizon consistently identifies Medicare eligible members; and
2. Properly establishes payment primacy; and
3. Correctly coordinates benefits with Medicare as per the terms of the Fund's benefit plan.

Sampling

The Fund prefers a pure random sampling (attribute sampling) of all transactions in the claim population. The sample size should vary in relationship to the expected confidence level and precision rate. The number of claims to be sampled should be based on the number of claims paid during the 2021-2022 plan years and should be statistically valid, however not less than 200. The sampled claims should be for amounts greater than $100.00 and all claims in excess of $20,000.

The level of accuracy should be consistent with the industry standards established for claims audits.

On-Site Claim Testing

Tests should be made against claim administration policies, procedures and protocols specific to the claims Administrator under review as well as those generally accepted within the industry. Each claim should be tested with the following questions:

- Was the claimant eligible for benefits on the date(s) of service?
- Was the claim submitted within the specified time as defined by the plan?
- Were managed care discounts and contractual provisions applied correctly?
- Were the procedures covered, billed and paid?
- Were claims for multiple procedures, bilateral procedures, unbundled services and experimental prescription drugs/services submitted to the appropriate levels for review and adjudicated accurately?

- Were benefit coordination and subrogation accurately determined if the claimant had other coverage available?
- Did the correct claimant or assignee receive payment?
- Did the claim contain all required information and was it coded properly in the claim processing system?
- Were benefits applied in accordance with plan requirements?
- Were coinsurance amounts and application of co-payments, out of pocket limits and deductibles accurate?
- Were allowable charge limitations of the plan correctly applied?
- Were preauthorization, second surgical opinion and ambulatory procedures followed and documented when appropriate?
- Was the claim paid only once?
- Did claim payment response time meet generally accepted industry standards?

All potential errors will be documented, and the Administrator will be given the opportunity during the on-site phase to review each questionable claim and to provide additional documentation substantiating its accuracy. The Proposer will specifically identify any systemic errors that may result in consistent errors beyond the audit sample. The Administrator will be given the opportunity to identify any additional errors as a result of systemic errors.

Reporting

The Proposer will evaluate and report the results of the operational review, the claims administration audit and review the data accumulated. Proposer shall make recommendations for improvement, if necessary.

The report will address the following:

- Average turnaround time
- Payment accuracy (defined as the number of claims with correct payments divided by the total number of claims), processing accuracy (defined as the number of claims with no payments or procedural errors divided by the total number of claims) and financial accuracy (defined as the total benefits paid correctly divided by the total of all benefits paid);
- Quality assurance programs
- Procedures for coordination of benefits, unusual or excessive claims
- How telephone inquiries were handled
- How pending claims were handled
- Controls against duplicate payments

- Available management reports
- Procedures for handling employee questions and claim disputes practices
- Employee submitted claims communication materials and resolution procedures

Fees

Your proposal should be based upon time and estimated expenses with a cap amount not to be exceeded.

Service Team

Please list names, titles, functions and background.

Timing

It is expected that an Auditor will be selected no later than November 22, 2022, and the audit conducted in January 2023. The final audit report must be delivered 60 days after claims audit on-site visit.

Submission of Quotes

All quotes for audit services should be returned to:

Middlesex County Joint Health Insurance Fund
Attention: Mr. Joe Pruiti
Office of the County Comptroller, 3rd Floor
County Administration Building
75 Bayard Street
New Brunswick, NJ 08903

All quotes should be returned on or before 12:00 noon, Wednesday, October 26, 2022

Contact Person for questions on Claims Audit

Lynn Collins or Dave Hissey

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Chadds Ford, PA 19317
610-388-0600

All proposals must be submitted in accordance with the attached Standardized Submission Requirements and Selection Criteria established by the Middlesex County Joint Health Insurance Fund as its Fair and Open Public Solicitation Process for Professional Services.