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U.S. OFFICE OF PERSONNEL MANAGEMENT  
OFFICE OF THE INSPECTOR GENERAL  
OFFICE OF AUDITS

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# Final Audit Report

Audit of Claims Processing and Payment Operations at  
Hawaii Medical Service Association as a  
Participating Health Maintenance Organization

Report Number 1D-87-00-19-014  
October 15, 2019

# EXECUTIVE SUMMARY

## *Audit of Claims Processing and Payment Operations at Hawaii Medical Service Association as a Participating Health Maintenance Organization*

Report No. 1D-87-00-19-014

October 15, 2019

### **Why Did We Conduct The Audit?**

The objectives of our audit were to determine whether Hawaii Medical Service Association (Plan), in its role as a health maintenance organization, charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of the contract with the U.S. Office of Personnel Management (OPM). Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

### **What Did We Audit?**

The Office of the Inspector General has completed a limited scope performance audit of the FEHBP claims processing and payment operations at Hawaii Medical Service Association in its role as a health maintenance organization. The Plan's service area includes the islands of Hawaii. The audit covered claim payments from January 1, 2016, through October 31, 2018, as reported in the Plan's Annual Accounting Statements.



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*Assistant Inspector General  
for Audits*

### **What Did We Find?**

Our limited scope performance audit determined that Hawaii Medical Service Association (HMSA) is properly pricing and paying claims on behalf of FEHBP members. Therefore, we conclude that HMSA is in compliance with the terms of its contract with OPM.

# ABBREVIATIONS

<b>FEHB</b>	<b>Federal Employees Health Benefits</b>
<b>FEHBP</b>	<b>Federal Employees Health Benefits Program</b>
<b>FEP</b>	<b>Federal Employee Program</b>
<b>HMO</b>	<b>Health Maintenance Organization</b>
<b>HMSA</b>	<b>Hawaii Medical Service Association</b>
<b>OPM</b>	<b>U.S. Office of Personnel Management</b>
<b>Plan</b>	<b>Hawaii Medical Service Association</b>

# TABLE OF CONTENTS

	<u>Page</u>
<b>EXECUTIVE SUMMARY</b> .....	i
<b>ABBREVIATIONS</b> .....	ii
<b>I. BACKGROUND</b> .....	1
<b>II. OBJECTIVES, SCOPE, AND METHODOLOGY</b> .....	2
<b>III. AUDIT FINDINGS</b> .....	4
A. Claim Pricing Reviews .....	4
B. Claim System Testing Review .....	5
<b>REPORT FRAUD, WASTE, AND MISMANAGEMENT</b>	

# I. BACKGROUND

This final audit report details the results of our limited scope audit of the Federal Employees Health Benefits Program's (FEHBP) claims processing and payment operations at Hawaii Medical Service Association (HMSA or Plan). The Plan is located in Honolulu, Hawaii. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General, as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations. Health insurance coverage is made available through contracts with various health insurance carriers.

The Plan is an experience-rated health maintenance organization (HMO) that provides health benefits to Federal enrollees and their families.<sup>1</sup> Enrollment is open to all Federal employees and annuitants in the Plan's service area, which includes all of Hawaii. The Plan's contract (CS 1058) with OPM is experience-rated. Thus, the costs of providing benefits in the prior year, including underwritten gains and losses that have been carried forward, are reflected in current and future years' premium rates. In addition, the contract provides that in the event of termination, unexpended program funds revert to the FEHBP Trust Fund. In recognition of these provisions, the contract requires that an accounting of program funds be submitted at the end of each contract year. The accounting is made on a statement of operations known as the Annual Accounting Statement.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Plan's management. In addition, management of the Plan is responsible for establishing and maintaining a system of internal controls.

There are no prior claims audits of the Plan. The results of this audit were discussed with the Plan throughout the audit. Since there were no audit findings, we did not hold a formal exit conference, and did not issue a draft report.

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<sup>1</sup> Members of an experience-rated HMO plan have the option of using a designated network of providers or using out-of-network providers. A member's choice in selecting one healthcare provider over another has monetary and medical implications. For example, if a member chooses an out-of-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

# II. OBJECTIVES, SCOPE, AND METHODOLOGY

## OBJECTIVES

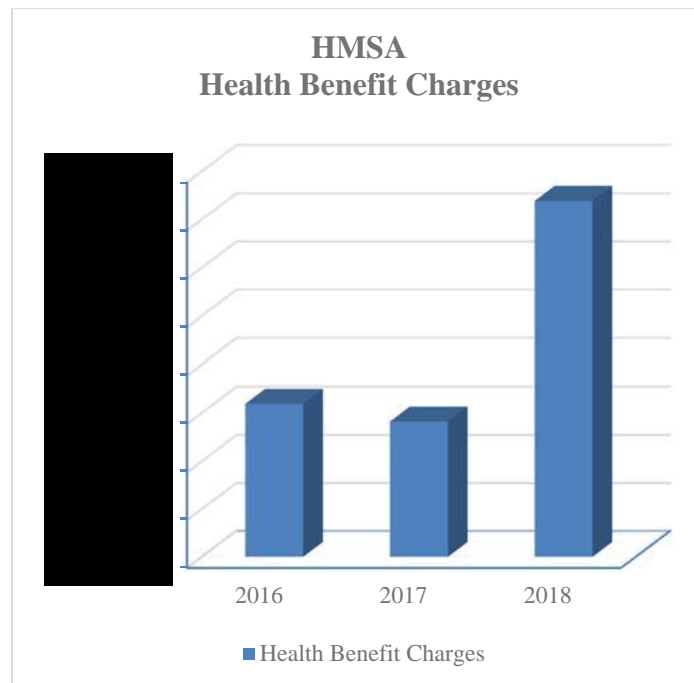
The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

## SCOPE

We conducted our performance audit in accordance with the generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the Plan's Annual Accounting Statements as they pertained to Plan code 87 for contract years 2016 through 2018 (see Exhibit I). During this period, the Plan paid approximately \$ [REDACTED] in health benefit charges.

**Exhibit I – Health Benefit Charges**



From a population of claims reimbursed from January 1, 2016, through October 31, 2018, we utilized SAS to judgmentally select various samples for review. Specifically, we reviewed approximately 234 claims, totaling \$741,432 in payments for proper adjudication. We used the FEHBP contract, the 2016 through 2018 Service Benefit Plan brochures, and the Plan's provider agreements to verify that the sampled claims were properly priced and paid. The results of our samples were not projected to the universe of claims.

## **METHODOLOGY**

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. Our audit approach consisted mainly of substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract, the applicable procurement regulations (i.e., Federal Acquisition Regulations and Federal Employees Health Benefits Acquisition Regulations, as appropriate), and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan is in compliance with the provisions of the contract relative to claim payments. A summary of our reviews is noted and explained in detail in the "Audit Findings" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the Plan. Due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. However, while utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

The audit was performed at the Plan's office in Honolulu, Hawaii from March 4, 2019, through March 14, 2019. Audit fieldwork was also performed at our offices in Cranberry Township, Pennsylvania; and Jacksonville, Florida through August 2019.

# III. AUDIT FINDINGS

## A. Claims Pricing Reviews

Our audit reviews did not detect any significant concerns with the Plan’s process for pricing and paying FEHBP claims, and we conclude that the Plan is in compliance with the terms of its contract with OPM. Exhibit II summarizes the reviews that were performed on claim payments made by HMSA.

**Exhibit II – Summary of Samples Selected for Review**

Review	Total Population		Sample		
	Claim Count	Amount Paid	Selection Methodology	Claim Count	Amount Paid
1. System Pricing	872,806	\$496,941,816	Judgmental	156	\$263,806
2. Unlisted Procedure Codes	25,622	\$63,090,050	Judgmental	40	\$322,781
3. Veterans Affairs	1,573	\$1,497,540	Judgmental	26	\$153,155
4. Chiropractic & Massage	554	\$10,322	Judgmental	12	\$1,690
<b>Totals</b>				<b>234</b>	<b>\$741,432</b>

### Populations Reviewed and Sample Selection Methodologies:

1. **System Pricing Review** - Our population consisted of all claims with an amount paid greater or equal to \$100. We generated a random sample of 807 claims with different place of service indicators. From this sample, we judgmentally selected 156 claims that were stratified by place of service (e.g., inpatient hospital or provider office). We judgmentally determined the sample size from the number of sampled items from each place of service stratum. Also, we judgmentally selected one provider from each place of service from our sample, for a total of 22 providers, to verify whether their contract rates were accurately updated in the Plan’ pricing system.
2. **Unlisted Procedure Code Review** - We identified all claims with a reimbursement of \$10 or higher and that contained an unlisted or miscellaneous procedure code. From this population, we judgmentally selected 40 high dollar claims that were stratified by procedure code.
3. **Veterans Affairs Review** - Our universe consisted of all claims paid to Veterans Affairs service providers. We judgmentally selected one claim from each place of service for each location, using the physical address (i.e., zip code) of the service provider. If there were multiple facility types, we selected a claim for each facility type to arrive at a total of 26 claims selected for review.



4. **Chiropractic and Massage Review** - Our population consisted of all claims containing a chiropractic procedure code that was incurred prior to January 1, 2018, and all claims with a therapeutic massage procedure code incurred during the scope of our audit. We judgmentally selected for review all claims paid greater than \$100.

## **B. Claims System Testing Review**

We created 44 test claims based on common claim scenarios billed to health insurance carriers. For each test claim, we slightly modified each claim to replicate the reprocessing of these common claim scenarios in order to test the Plan's local system for adjudicating claims. The exercise involved processing our sample test claims through the Plan's local system and evaluating the manner in which the claims were adjudicated.

The claims system processing review provided an opportunity to test a sample of claims to ensure that the Plan's local claim processing system is properly pricing and paying claims. During the claim cycle process, the Plan's local system adjudicates claims for pricing and medical editing and applies Federal Employee Program (FEP) member benefits.

We were able to conduct a complete test of the Plan's claims adjudication process to validate the system's processing controls related to the samples presented to the Plan. The exercise involved processing our sample test claims through the Plan's local system and FEP Direct and evaluating the manner in which the Plan's system adjudicated the claims. Our test did not identify any issues. Therefore, we conclude that the Plan's local claims' system is properly validating and paying claims.



## **Report Fraud, Waste, and Mismanagement**

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Washington Metro Area: (202) 606-2423

**By Mail:** Office of the Inspector General  
U.S. Office of Personnel Management  
1900 E Street, NW  
Room 6400  
Washington, DC 20415-1100