



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

Final Audit Report

**AUDIT OF
HAWAII MEDICAL SERVICE ASSOCIATION
HONOLULU, HAWAII**

Report Number 1D-87-00-17-038

June 11, 2018

EXECUTIVE SUMMARY

Audit of Hawaii Medical Service Association

Report No. 1D-87-00-17-038

June 11, 2018

Why did we conduct the audit?

We conducted this limited scope audit to obtain reasonable assurance that Hawaii Medical Service Association (Plan) is complying with the provisions of the Federal Employees Health Benefits Act and regulations that are included, by reference, in the Federal Employees Health Benefits Program (FEHBP) contract. The objectives of our audit were to determine if the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the contract.

What did we audit?

Our audit covered miscellaneous health benefit payments and credits, such as refunds and pharmacy drug rebates, from 2012 through February 2017, and administrative expenses from 2012 through 2016. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from 2012 through February 2017, and the Plan's Fraud and Abuse Program for 2015 and 2016. Due to concerns with the Plan's working capital funds and management of FEHBP funds, we expanded our scope to also include these funds from March 2017 through June 2017 and July 2017, respectively.



Michael R. Esser
*Assistant Inspector General
for Audits*

What did we find?

We questioned \$1,208,306 in cash management activities and lost investment income (LII). We also identified a procedural finding regarding the Plan's Fraud and Abuse Program. The Plan agreed with all of the questioned amounts and the procedural finding for the Fraud and Abuse Program.

Our audit results are summarized as follows:

- Miscellaneous Health Benefit Payments and Credits – The audit disclosed no significant findings pertaining to miscellaneous health benefit payments and credits, except for the finding pertaining to the Plan's improper management of FEHBP funds noted in the "Cash Management" section. Overall, we concluded that the Plan returned health benefit refunds and recoveries, including pharmacy drug rebates, to the FEHBP and properly charged miscellaneous payments to the FEHBP.
- Administrative Expenses – The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the Plan's administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with the contract and applicable laws and regulations.
- Cash Management – We determined that the Plan held an excess working capital deposit of \$1,132,580 in the dedicated FEHBP investment account as of June 30, 2017. We also questioned a net amount of \$75,726 because the Plan improperly managed funds, consisting of \$86,604 (net) owed to the Plan for reimbursable costs and \$162,330 due to the FEHBP for LII calculated on funds deposited untimely into the dedicated FEHBP investment account.
- Fraud and Abuse Program – We determined that the Plan is *not* in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in FEHBP Carrier Letter 2014-29. We also identified several non-compliance issues regarding the Plan's Fraud and Abuse Program policies and procedures and 2016 Annual Fraud, Waste, and Abuse Report.

ABBREVIATIONS

CFR	Code of Federal Regulations
CL	Carrier Letter
FAR	Federal Acquisition Regulations
FEHB	Federal Employees Health Benefits
FEHBAR	Federal Employees Health Benefits Acquisition Regulations
FEHBP	Federal Employees Health Benefits Program
FWA	Fraud, Waste, and Abuse
Guidelines	Letter of Credit System Guidelines
HMO	Health Maintenance Organization
HMSA or Plan	Hawaii Medical Service Association
LII	Lost Investment Income
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
PBM	Pharmacy Benefit Manager
SIU	Special Investigations Unit

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I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at the Hawaii Medical Service Association (HMSA or Plan). The Plan is located in Honolulu, Hawaii.

The audit was performed by the Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as established 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 (CFR). 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.¹ 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.

¹ 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.

All findings from our prior audit of the Plan (Report No. 1D-87-00-12-041, dated February 21, 2013), covering contract years 2007 through 2011, have been satisfactorily resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan officials throughout the audit and at an exit conference on December 21, 2017; and were presented in detail in a draft report, dated January 19, 2018. The Plan's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

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 objectives were as follows:

Miscellaneous Health Benefit Payments and Credits

- To determine whether miscellaneous payments charged to the FEHBP were in compliance with the terms of the contract.
- To determine whether credits and miscellaneous income, such as refunds and pharmacy drug rebates, relating to FEHBP benefit payments were returned timely to the FEHBP.

Administrative Expenses

- To determine whether administrative expenses charged to the contract were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations.

Cash Management

- To determine whether the Plan handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP.

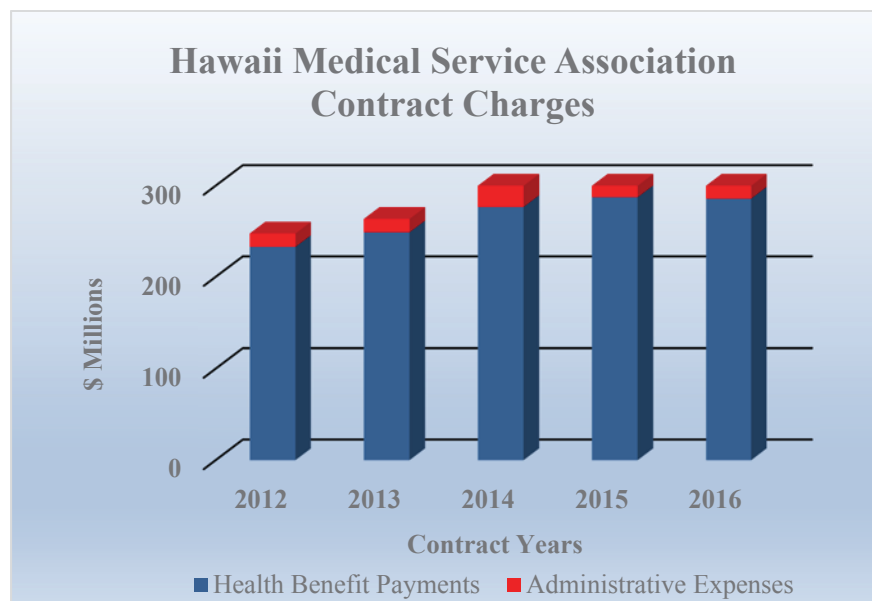
Fraud and Abuse Program

- To determine whether the Plan's communication and reporting of fraud and abuse cases were in compliance with the terms of Contract CS 1058 and FEHBP Carrier Letter 2014-29.

SCOPE

We conducted our limited scope performance audit in accordance with 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 for contract years 2012 through 2016. During this period, the Plan paid approximately \$1.3 billion in FEHBP health benefit payments and charged the FEHBP \$108 million in administrative expenses.



Specifically, we reviewed miscellaneous health benefit payments and credits (e.g., cash and auto recoupment refunds, pharmacy and medical drug rebates, and fraud recoveries) and the Plan's cash management activities and practices from 2012 through February 2017, as well as administrative expenses from 2012 through 2016. We also reviewed the Plan's Fraud and Abuse Program activities and practices from 2015 through 2016. Due to concerns with the Plan's working capital deposit and management of FEHBP funds, we expanded our scope to also include these items from March 2017 through June 2017 and July 2017, respectively.

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. This was determined to be the most effective approach to select areas of audit. For those areas selected, we primarily relied on 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 (FAR) and Federal Employees Health Benefits Acquisition Regulations (FEHBAR), as appropriate), and the laws and regulations governing the FEHBP. The results of our tests indicate that, with respect to the items tested, the Plan did not comply with all provisions of the contract and Federal procurement regulations. Exceptions noted in the areas reviewed are set forth in detail in the "Audit Findings and Recommendations" 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 various information systems involved. 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 July 18, 2017, through August 11, 2017. Audit fieldwork was also performed at our offices in Jacksonville, Florida and Washington, D.C. through January 18, 2018. Throughout the audit process, we encountered several instances where the Plan responded untimely, or initially provided incomplete responses, to various requests for explanations and supporting documentation. As a result, completion of our audit work and issuance of our draft and final reports were delayed.

METHODOLOGY

We obtained an understanding of the internal controls over the Plan's financial, cost accounting, and cash management systems by inquiry of Plan officials.

We interviewed Plan personnel and reviewed the Plan's policies, procedures, and accounting records during our audit of miscellaneous health benefit payments and credits. For the period 2012 through February 28, 2017, we also judgmentally selected and reviewed the following FEHBP items:

Health Benefit Refunds

- A high dollar sample of 43 health benefit refund cash receipts, totaling \$2,584,993, (from a universe of 7,310 FEHBP refund cash receipt amounts, totaling \$4,337,870). Our high dollar sample included all refund cash receipt amounts of \$10,000 or more.
- A high dollar sample of 77 health benefit refunds returned via auto recoupments, totaling \$18,080,995 (from a universe of 58,445 FEHBP refunds returned via auto recoupments, totaling \$60,739,354). Our high dollar sample included all auto recoupment amounts of \$100,000 or more.

Other Health Benefit Payments, Credits, and Recoveries

- 21 high dollar miscellaneous health benefit payment amounts, totaling \$15,827,158, from a universe of 74 miscellaneous health benefit payment amounts, totaling \$54,807,016, that were charged to the FEHBP during the audit scope. For this sample, we judgmentally selected three or more (a maximum of six) high dollar payment amounts from each year for 2012 through 2016. These miscellaneous health benefit payments mostly included charges that were applicable to the Plan's programs for Disease and Utilization Management, Quality, and Patient Centered Medical Homes.
- All 24 pharmacy drug rebate amounts, totaling \$29,606,340, for the audit scope.
- 16 high dollar fraud recoveries, totaling \$1,564,384, from a universe of 207 fraud recoveries, totaling \$2,136,171. For this sample, we selected all fraud recoveries of \$50,000 or more.
- 24 high dollar subrogation recoveries, totaling \$829,781, from a universe of 312 subrogation recoveries, totaling \$1,134,077. For this sample, we selected all subrogation recoveries of \$10,000 or more.
- All 28 medical drug rebate amounts, totaling \$180,169, for the audit scope.

We reviewed these samples to determine if health benefit refunds and recoveries, including pharmacy and medical drug rebates, were timely returned to the FEHBP and if miscellaneous payments were properly charged to the FEHBP. Since we did not use statistical sampling, the results of these samples were not projected to the applicable universes.

We judgmentally reviewed administrative expenses charged to the FEHBP for contract years 2012 through 2016. Specifically, we reviewed administrative expenses relating to the Patient Protection and Affordable Care Act that were allocated and charged to the FEHBP (i.e., health insurance provider, transitional reinsurance, and “Patient-Centered Outcomes Research Institute” fees). We used the FEHBP contract, the FAR, the FEHBAR, and/or the Affordable Care Act (Public Law 111-148) to determine if these charges were allowable, allocable, and reasonable.

We reviewed the Plan’s cash management activities and practices to determine whether the Plan handled FEHBP funds in accordance with Contract CS 1058 and applicable laws and regulations. Specifically, we reviewed a sample of 76 letter of credit account drawdown amounts, totaling \$107,682,167 (from a universe of 1,209 letter of credit account drawdowns, totaling \$1,480,145,605, during the period 2012 through February 28, 2017), for the purpose of determining if the Plan’s letter of credit account drawdowns were appropriate and adequately supported.² We also reviewed the Plan’s working capital calculations, adjustments and/or balances from 2012 through June 30, 2017; United States Treasury offsets and interest income transactions from 2012 through February 28, 2017; and the Plan’s dedicated FEHBP investment account activity from 2012 through July 31, 2017, and the balance as of July 31, 2017.

We also interviewed the Plan’s Special Investigations Unit (SIU) regarding the effectiveness of the Fraud and Abuse Program, as well as reviewed the Plan’s communication and reporting of fraud and abuse cases to test compliance with Contract CS 1058 and FEHBP Carrier Letter 2014-29.

² Our sample included a week of letter of credit account drawdowns (representing four or five drawdown amounts) judgmentally selected from each semi-annual period from 2012 through 2014, and two weeks of letter of credit account drawdowns (representing four or five drawdown amounts for each week) judgmentally selected from each semi-annual period from 2015 through February 28, 2017. Since we did not use statistical sampling, the sample results were not projected to the universe of letter of credit account drawdowns.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. MISCELLANEOUS HEALTH BENEFIT PAYMENTS AND CREDITS

The audit disclosed no significant findings pertaining to miscellaneous health benefit payments and credits, except for the finding pertaining to improper management of FEHBP funds noted in the “Cash Management” section. Overall, we concluded that the Plan timely returned health benefit refunds and recoveries, including pharmacy drug rebates, to the FEHBP and properly charged miscellaneous payments to the FEHBP.

B. ADMINISTRATIVE EXPENSES

The audit disclosed no findings pertaining to administrative expenses. Overall, we concluded that the administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with Contract CS 1058 and applicable laws and regulations.

C. CASH MANAGEMENT

1. Excess Working Capital Deposit \$1,132,580

As of June 30, 2017, the Plan held a working capital deposit of \$1,132,580 over the amount needed to meet the Plan’s daily cash needs for FEHBP claim payments.

OPM’s “Letter of Credit System Guidelines” (Guidelines), dated May 2009, state: “Carriers should maintain a working capital balance equivalent to an average of 2 days of paid claims. The working capital fund should be established using federal funds. Carriers are required to monitor their working capital funds on a monthly basis and adjust if necessary on a quarterly basis. . . . The working capital is not required but strongly recommended.” Based on these Guidelines, the Carrier’s working capital calculation must also exclude electronic fund transfers.

In addition, based on the regulations governing the financing of Federal programs by the letter of credit method, as established in 31 CFR 205 (Treasury Department Circular No. 10750), electronic fund transfers should not be included in the Plan’s working capital calculation. These instructions are established under the provisions of Treasury Department Circular No. 1083 (Regulations Governing the Utilization of the U.S. Treasury Financial Communication Systems), 5 CFR Part 890, and 48 CFR Chapter 16.

Based on industry practice (e.g., other FEHBP experience-rated Carriers), the working capital deposit should be recalculated on a regular basis to determine if the amount currently maintained is adequate to meet the Carrier's daily cash needs for FEHBP claim payments. If the working capital deposit amount is over or under funded, then the Plan should make an appropriate adjustment.

We noted that the Plan reviewed the working capital deposit on a regular basis (usually quarterly) from 2012 through February 28, 2017.³ When reviewing the Plan's working capital calculation (as of December 31, 2016), we determined that the Plan included the following items in the calculation: check presentments and electronic fund transfers for FEHBP claim payments; electronic fund transfers to the Pharmacy Benefit Manager (PBM) for pharmacy drug claims; and electronic fund transfers for dental claims and applicable excise taxes. Based on the Guidelines, the Plan's working capital calculation must exclude electronic fund transfers.

In our opinion, by including the weekly or biweekly electronic fund transfers to the PBM in the Plan's working capital calculation, as well as the electronic fund transfers for the dental claims and applicable excise taxes, the Plan is significantly overstating the working capital deposit amount that is actually needed to meet the Plan's daily financial obligations for the FEHBP experience-rated HMO plan. Since the Plan pays these health benefit costs by electronic fund transfers on behalf of the FEHBP from the Plan's corporate account, the Plan has adequate time to request and withdraw these funds from the letter of credit account to timely reimburse themselves for these costs.

The Plan held an excess working capital deposit of \$1,132,580 in the dedicated FEHBP investment account as of June 30, 2017.

During the fieldwork phase, the Plan recalculated the working capital deposit (excluding electronic fund transfers) and determined that, as of June 30, 2017, the working capital deposit should only be \$3,481,799. However, the Plan held a working capital deposit of \$4,614,379. We reviewed and accepted the Plan's working capital calculation as of June 30, 2017. Therefore, as of that date, the Plan held a working capital deposit with an excess amount of \$1,132,580 (\$4,614,379 minus \$3,481,799) over the amount actually needed to meet the Plan's daily cash needs for FEHBP claim payments. Since the Plan maintained these excess working capital funds in the dedicated FEHBP investment account, lost investment income (LII) is not applicable.

³ Although the audit scope for the Plan's cash management activities and practices initially included 2012 through February 2017, we expanded the scope for the working capital funds to also include March 2017 through June 2017.

Plan Response:

The Plan agrees with this finding. The Plan returned the questioned excess working capital funds to the FEHBP via letter of credit account drawdown adjustment. Going forward, the Plan will properly calculate the working capital deposit in accordance with the requirements.

OIG Comment:

As part of our review, we verified that the Plan returned the questioned excess working capital funds of \$1,132,580 to the FEHBP in September 2017.

Recommendation 1

We recommend that the contracting officer require the Plan to return \$1,132,580 to the FEHBP for the excess working capital deposit. However, since we verified that the Plan returned \$1,132,580 to the FEHBP for the excess working capital deposit, no further action is required for this questioned amount.

Recommendation 2

We recommend that the Plan implement corrective actions to ensure that the working capital deposit is properly calculated in accordance with the Guidelines and applicable regulations. If an exception for the working capital calculation is necessary, then the Plan should request prior approval (a waiver) from the contracting officer.

Recommendation 3

Since the use of electronic fund transfers by the experience-rated Carriers to pay FEHBP claim payments have substantially increased in the past several years, we recommend that the contracting officer(s) and/or OPM's Benefits Insurance Accounting Office review and revise (if necessary) the Guidelines, including the formula for the working capital calculation, and propose regulation changes if applicable.

2. Improper Management of Funds

\$75,726

The Plan did not properly manage or account for all FEHBP funds from 2012 through July 2017. As a result, we are questioning a net amount of \$75,726 for this audit finding, consisting of \$86,604 (net) owed to the Plan for reimbursable costs and \$162,330 due to the FEHBP for applicable LII calculated on funds deposited untimely into the dedicated FEHBP investment account.

Contract CS 1058, Part III, section 3.5 (a) states, "The Carrier . . . shall keep all FEHBP funds for this contract (cash and investments) physically separate from funds obtained from other sources." 48 CFR 1632.771 (c) states, "FEHBP funds shall be maintained separately from other cash and investments of the carrier or underwriter."

48 CFR 31.201-5 states, "The applicable portion of any . . . rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the Government either as a cost reduction or by cash refund." Also, based on Contract CS 1058 (Part II, Section 2.3 (i)), all health benefit refunds and recoveries, including pharmacy and medical drug rebates, must be deposited into the working capital or investment account within 30 days and returned to or accounted for in the LOCA within 60 days after receipt by the Plan.

FAR 52.232-17(a) states, "all amounts that become payable by the Contractor . . . shall bear simple interest from the date due . . . The interest rate shall be the interest rate established by the Secretary of the Treasury as provided in 41 U.S.C. 7109, which is applicable to the period in which the amount becomes due, as provided in paragraph (e) of this clause, and then at the rate applicable for each six-month period as fixed by the Secretary until the amount is paid."

The Plan's dedicated FEHBP investment account generally includes working capital funds, approved letter of credit account drawdown reimbursements, health benefit refunds and recoveries from providers and subscribers, interest income earned, and other cash items identified as due to the FEHBP. Based on Contract CS 1058, all funds deposited into the dedicated FEHBP investment account (such as health benefit refunds and recoveries, interest income, and excess working capital funds), should be returned to the FEHBP by adjusting the letter of credit account within 60 days after receipt by the Plan. In addition, approved reimbursements from the letter of credit account that are deposited into the dedicated FEHBP investment account should be timely transferred from this investment account to the Plan's corporate account.

As part of the Plan's cash management process, the Plan pays numerous types of costs from HMSA's corporate bank account on behalf of the FEHBP (such as pharmacy drug claims, dental claims and applicable excise taxes, and radiology claims). The Plan also receives an estimated monthly amount for administrative expenses (based on the contract limitation) and an approved monthly amount for the service charge. These monthly amounts are reimbursed to the Plan through the letter of credit account drawdown process and deposited into the Plan's dedicated FEHBP investment account, and then netted against certain amounts (such as pharmacy and medical drug rebates) due to the FEHBP.

For the period 2012 through July 2017, we noted that the Plan had not deposited certain types of miscellaneous health benefit recoveries (such as pharmacy and medical drug rebates) into the dedicated FEHBP investment account.⁴ Instead, the Plan deposited these recoveries into HMSA's corporate bank account and then returned these funds to the FEHBP through the Plan's "netting" process. Specifically, the Plan netted the amount owed to the FEHBP for these miscellaneous health benefit recoveries against the amount owed to the Plan for items such as administrative expenses, miscellaneous health benefit payments, and the service charge.

The Plan did not deposit funds into and/or transfer funds from the dedicated FEHBP investment account on a consistent basis.

After the Plan performs the netting process, the approved reimbursements from the letter of credit account are deposited into the dedicated FEHBP investment account. Based on the netting process, if the amount owed to the Plan is more than the amount due to the FEHBP, the Plan transfers the difference to

HMSA's corporate account. In this situation, the funds owed to the Plan should be timely and totally transferred from the dedicated FEHBP investment account to HMSA's corporate account. However, during our review of health benefit refunds and recoveries, pharmacy drug rebates and medical drug rebates, and miscellaneous health benefit payments, we noted the Plan did not deposit funds into and/or transfer funds from the dedicated FEHBP investment account on a consistent basis. This made reviewing these items challenging to complete. Based on our experience with auditing the FEHBP experience-rated Carriers, we have noted that substantially all of these Carriers deposit health benefit refunds and recoveries, pharmacy drug rebates, and/or medical drug rebates into the dedicated FEHBP investment account and then return the funds to the FEHBP via letter of credit account drawdown adjustments.

⁴ Although the audit scope for miscellaneous health benefit payments and credits initially included 2012 through February 2017, we expanded the scope to include March 2017 through July 2017 for these payments and credits, if included in the Plan's netting process.

Based on our review, we noted the following exceptions:

- During our on-site fieldwork phase, we met with the Plan on several occasions to discuss the Plan's netting process and procedures for returning health benefit refunds and recoveries, including pharmacy and medical drug rebates, to the FEHBP. The Plan could not adequately explain the netting process and demonstrate that these funds were deposited into the dedicated FEHBP investment account and returned to the letter of credit account. Therefore, we requested the Plan to provide a detailed analysis of the netting process from 2012 through July 2017, for the purpose of demonstrating if all health benefit refunds and recoveries, including pharmacy and medical drug rebates, were returned to the FEHBP, and thus making the Plan's dedicated FEHBP investment bank account whole. The Plan provided an analysis detailing the amounts owed to the Plan (reimbursable costs) that were netted against the amounts due to the FEHBP (such as pharmacy and medical drug rebates). Based on the Plan's analysis, the Plan is owed an additional \$86,604 (net) for payments made on behalf of the FEHBP that inadvertently had not been transferred from the dedicated FEHBP investment account into HMSA's corporate account. We reviewed and accepted the Plan's analysis.
- As part of the analysis, the Plan also calculated LII on all FEHBP funds (such as pharmacy and medical drug rebates) that were untimely deposited into the dedicated FEHBP investment account. Based on the Plan's calculation, the FEHBP is due LII of \$162,330 on these funds. We reviewed and accepted the Plan's LII calculation.

In total, we are questioning a net amount of \$75,726 for this audit finding. This net questioned amount consists of \$86,604 (net) owed to the Plan for cost reimbursements that inadvertently had not been transferred from the dedicated FEHBP investment account into HMSA's corporate account, and \$162,330 due to the FEHBP for applicable LII calculated on funds that were untimely deposited into the dedicated FEHBP investment account.

Plan Response:

The Plan agrees with this finding. The Plan returned the questioned LII of \$162,330 to FEHBP. However, the Plan states, "HMSA has not charged the FEHBP for the \$86,604 as we are waiting for the completion of the Office of the Inspector General Audit and OPM permission to do so.

Going forward, HMSA will provide to OPM evidence or supporting documentation that HMSA has implemented the necessary corrective actions to improve the netting process and accountability of FEHBP funds as reported in the audit finding. HMSA will also deposit, as required, all health benefit refunds and recoveries, including pharmacy and medical drug rebates, into the working capital or investment account within 30 days and return to or account for in the LOCA [letter of credit account] within 60 days after receipt by the Plan.”

OIG Comment:

As part of our review, we verified that the Plan returned the questioned LII to the FEHBP on August 25, 2017.

Recommendation 4

We recommend that the contracting officer require the Plan to return \$162,330 to the FEHBP for questioned LII calculated on the funds that were deposited untimely into the FEHBP investment account. However, since we verified that the Plan returned \$162,330 to the FEHBP for the questioned LII, no further action is required for this LII amount.

Recommendation 5

We recommend that the contracting officer allow the Plan to charge the FEHBP \$86,604 (net) for costs that had not been reimbursed to the Plan.

Recommendation 6

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary corrective actions to improve the netting process and accountability of FEHBP funds (as reported in the audit finding).

Recommendation 7

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan now deposits all health benefit refunds and recoveries, including pharmacy and medical drug rebates, into the dedicated FEHBP working capital or investment account within 30 days and then returns these funds to the letter of credit account within 60 days after receipt.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit

Procedural

The Plan did not report, or did not timely report, all fraud and abuse cases to the OIG.

The Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases that are set forth in FEHBP Carrier Letter (CL) 2014-29. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the OIG. Without awareness of these existing potential fraud and abuse issues, the OIG cannot investigate the broader impact of these potential issues on the FEHBP as a whole. We also identified several non-compliance issues regarding the Plan’s Fraud and Abuse Program process and procedures and the Plan’s 2016 Annual Fraud, Waste, and Abuse Reports.

Contract CS 1058, Part III, Section 1.9 (a) states, “The Carrier must submit to OPM an annual analysis of the costs and benefits of its FWA [Fraud, Waste, and Abuse] program. The Carrier must submit annual reports to OPM by March 31 addressing . . . 9) Dollars Identified as Loss; 10) Estimated Financial Losses; 11) Non-Recoverable Loss; 12) Dollars Recovered by SIU and/or Vendor Activities; . . . 16) Prevented Loss”

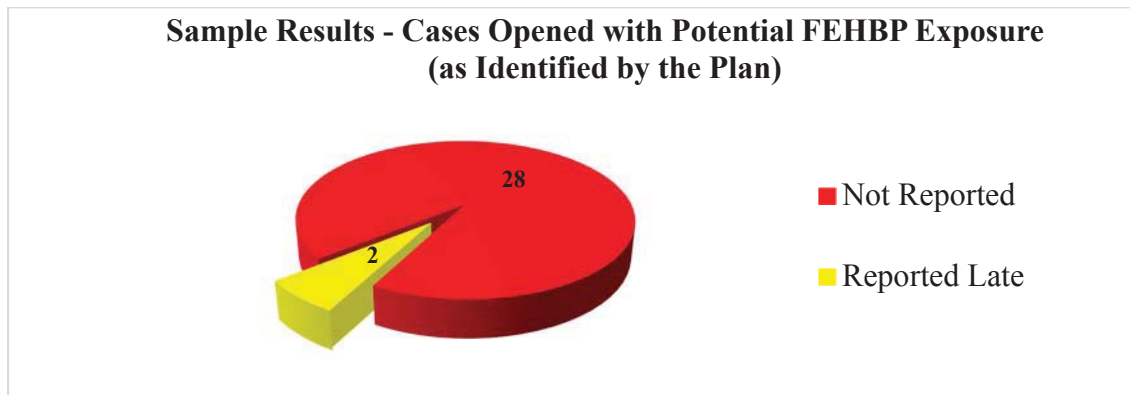
CL 2014-29 (Office of Personnel Management Federal Employees Health Benefits Fraud, Waste and Abuse), dated December 19, 2014, states that all Carriers “are required to submit a written notification to the OPM-OIG within 30 working days when there is potential reportable [fraud, waste, or abuse] that has occurred against the FEHB Program. OPM-OIG considers a potential reportable [fraud, waste, or abuse] as, after preliminary review of the complaint, the carrier takes an affirmative step to investigate the complaint.” There is no dollar threshold for this requirement.

Part II (Fraud and Abuse - Carrier Actions) of CL 2014-29 states, “FEHBP Carriers must, at a minimum, perform the following activities to prevent, detect, investigate, and report FEHBP [fraud, waste, and abuse]: . . . Develop programs to prevent, detect, and identify persons and organizations involved in suspicious claim activity . . . Provide claims data upon request from OPM-OIG . . . and track all data requests separately. . . . Provide liaison and investigative support to OPM-OIG . . . upon request. . . . Track all provider, member, and pharmacy case notifications sent to OPM-OIG and all other law enforcement agencies, and provide an annual report of such activity to OPM . . . Provide annual fraud, waste, and or abuse reports (medical and pharmacy), due March 31st, to Health Insurance, Federal Employees Insurance Operations, [OPM]”

Part III (Industry Standards) of CL 2014-29 states, “All FEHB Carriers must have, at a minimum . . . commercial industry-based program standards to prevent, detect, investigate, and report all FEHB related [fraud, waste, and abuse].” For example, each Carrier must have a fraud, waste, and abuse manual with prevention, detection, investigation, and reporting procedures. This fraud, waste, and abuse manual must include all of the Carrier’s policies and procedures included in the Carrier’s Fraud and Abuse Program.

Attachment 1, Part VI (Program Cost Evaluation) of CL 2014-29 states, “Fraud, Waste, and Abuse Program Costs - Include all related SIU Costs, including salaries, benefits for staffing, travel, and training, which are only related to your FEHB [fraud, waste, and abuse] program costs.”

For the period January 1, 2015 through December 31, 2016, the Plan opened [REDACTED] fraud and abuse cases with potential FEHBP exposure. From this universe, we selected and reviewed a judgmental sample of 30 cases for the purpose of determining if the Plan timely reported these cases to the OIG. Based upon our review of these 30 cases, we determined that 28 cases were not reported to the OIG and 2 cases were untimely reported to the OIG.



Ultimately, the Plan’s incomplete reporting of potential FEHBP cases to the OIG has resulted in a failure to meet the communication and reporting requirements that are set forth in CL 2014-29. The lack of notification by the Plan did not allow the OIG to investigate whether other FEHBP Carriers are exposed to the identified fraudulent activity. As a result, this lack of OIG notification by the Plan may result in additional improper payments being made by other FEHBP Carriers. This also does not allow the OIG’s Administrative Sanctions Group to be notified timely.

The following are additional non-compliance issues that were identified during discussions with the Plan's SIU and/or while reviewing the Plan's Fraud and Abuse Program policies and procedures as well as the Plan's 2016 Annual Fraud, Waste, and Abuse Report:

- The Plan did not enter or track the applicable pharmacy data reported in the 2016 Annual Fraud, Waste, and Abuse Report, stating that CVS, which is the Plan's Pharmacy Benefit Manager (PBM), entered this specific data. The Plan also did not review or verify the data entered by CVS in this report.
- In the 2016 Annual Fraud, Waste, and Abuse Report, the data related to the PBM's Fraud and Abuse Program should not be considered accurate or reliable if the Plan did not actually track or verify this data, especially since the PBM did not have a Fraud and Abuse Program. CVS specifically noted in the 2016 Annual Fraud, Waste, and Abuse Report that there was no Fraud and Abuse Program for the FEHBP pharmacy benefits in 2016. Therefore, the exclusion of the FEHBP costs, but inclusion of reported recoveries and actual savings, results in the inflation of the Plan's return on investment for fraud, waste, and abuse.
- CVS has a [REDACTED] [REDACTED] These program services are purchasable software programs that CVS offers clients, including HMSA. While we agree that these CVS software program edits would help identify potential adverse drug interactions and/or over utilization, we do not believe that these CVS software edits represent a Fraud and Abuse Program.
- In 2016, all FEHBP Carriers were required to comply with Carrier Letter 2014-29. We noted that the Plan's 2016 Annual Fraud, Waste, and Abuse Report did not track or report identified losses, estimated financial losses, non-recoverable losses, recoveries, savings, and prevented losses for fraud, waste, and/or abuse cases related to pharmacy drug claims.
- The Plan's Fraud, Waste, and Abuse Process and Procedure Manual does not have PBM oversight and investigative procedures for tracking potential fraud, waste, and/or abuse leads, allegations, and/or cases that are received from the PBM.

Plan Response:

“Until the audit, HMSA was not in compliance with communication and reporting requirements as set forth in FEHBP CL 2014-29. Going forward, HMSA will comply with contract and Carrier Letter notification requirements by providing notification to OPM-OIG within 30 working days after determining if there is reportable [fraud, waste, or abuse] . . .

HMSA agrees that it did not enter, track, or validate the pharmacy data as set forth in the 2016 Annual FWA [Fraud, Waste, and Abuse] Report. In the future, HMSA will enter, track, and validate the pharmacy data as required by CL 2017-13.

HMSA agrees that it did not consistently track or validate the pharmacy data as set forth in the 2016 Annual FWA Report and that the ‘exclusion of FEHBP pharmacy costs but inclusion of recoveries and savings’ could have resulted in the inflation of HMSA’s return of investment. In the future, HMSA will accurately enter, track, validate, and report all information as required by CL 2017-13.

HMSA agrees that CVS has a [REDACTED], and these services, along with the [REDACTED], support HMSA’s FWA Program. In addition to the data analytic capabilities that assist in identifying potential FWA, these contracted services also provide targeted interventions, pharmacy audit referrals and continuous monitoring. HMSA agrees that these programs alone do not represent a FWA program.

HMSA agrees that in 2016, all FEHBP carriers were required to comply with [CL 2014-29] and that HMSA’s 2016 Annual FWA Report did not track or report the identified losses, estimated financial losses, and non-recoverable losses, recoveries, savings, and prevented loss for the pharmacy FWA program. In the future, HMSA will accurately enter, track, validate, and report all information as required by CL 2017-13.

Going forward, HMSA will be refining its processes to meet these requirements and document them in a revised FWA Manual.”

OIG Comment:

After reviewing the Plan's additional information in response to the non-compliance issues that were identified during our discussions with Plan officials and/or while reviewing the Plan's Fraud and Abuse Program policies and procedures and the Plan's 2016 Annual Fraud, Waste, and Abuse Report, we revised these non-compliance issues accordingly (see page 17), based on this additional information.

Recommendation 8

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are contained in CL 2014-29 and CL 2017-13 (OPM Federal Employees Health Benefits Fraud, Waste, and Abuse).⁵

Recommendation 9

We recommend that the contracting officer require the Plan to perform a comprehensive review (or self-assessment) of the Plan's Fraud and Abuse Program. The Plan should provide the results of this comprehensive review to the contracting officer as well as the applicable corrective actions that were implemented (and/or will be implemented) to ensure compliance with the requirements of the FEHBP contract and CL 2017-13.

Recommendation 10

We recommend that the contracting officer require the Plan to revise the Fraud, Waste, and Abuse Process and Procedure Manual to include investigative procedures and systematic information for tracking potential fraud, waste, and/or abuse leads, allegations, and/or cases that are received from the PBM. The Plan should also implement the necessary procedures to ensure proper PBM oversight.

⁵ CL 2017-13 (dated November 20, 2017) consolidates and updates the information from CL 2014-29, which is superseded by this guidance. CL 2017-13 also supplements guidance from the FEHBP contract (Section 1.9 – Plan Performance).

Recommendation 11

We recommend that the contracting officer verify that the Plan provides a complete and accurate 2017 Annual Fraud, Waste, and Abuse Report. We also recommend that the Plan provide the contracting officer complete documentation (or have available for onsite inspection) to support all entry items and data elements in this annual report.



February 16, 2018

██████████, Group Chief
 Experience-Rated Audits Group
 Office of the Inspector General
 U.S. Office of Personnel Management
 1900 E Street, Room 6400
 Washington, DC 20415-1100

Re: Audit of Hawaii Medical Service Association (HMSA)
Audit Report Number 1D-87-00-17-038

Dear ██████████:

This letter is in response to the above-referenced U.S. Office of Personnel Management (OPM) Draft Audit Report, issued on January 19, 2018, detailing the results of the limited scope audit of the Federal Employee Health Benefits Program (FEHBP) operations at HMSA. Our comments regarding the findings in this report are as follows.

C. CASH MANAGEMENT

1. Excess Working Capital (WC) Deposit **\$1,132,580**

As of June 30, 2017, the Plan held a WC deposit of \$1,132,580 over the amount needed to meet the Plan's daily cash needs for Federal Employee Health Benefit Program (FEHBP) claim payments.

Recommendation 1

We recommend that the contracting officer require the Plan to return \$1,132,580 to the FEHBP for the excess WC deposit. However, since we verified that the Plan returned \$1,132,580 to the FEHBP for the excess WC deposit, no further action is required for this amount.

Plan's Response

HMSA agrees with the finding. We have returned the excess WC, totaling \$1,132,579.81, to the FEHBP by adjusting the Letter of Credit (LOC) Account as of October 2, 2017. Going forward, HMSA will properly compute the WC deposit according to FEHBP requirements.

2. Improper Management of FEHBP Funds

\$75,726

The Plan did not properly manage or account for all FEHBP funds from 2012 through July 2017. As a result, we are questioning a net total amount of \$75,726 for this audit finding, consisting of \$86,604 for a net amount owed to the Plan and \$162,330 for applicable lost investment income (LII) due to the FEHBP.

Recommendation 2

We recommend that the contracting officer require the Plan to return the questioned LII to the FEHBP for funds that were not timely deposited into the dedicated FEHBP investment account. However, since we verified that the Plan returned the questioned LII to the FEHBP, no further action is required.

Recommendation 3

We recommend that the contracting officer allow the Plan to charge the FEHBP \$86,604 for costs that had not been reimbursed to the Plan.

Recommendation 4

We recommend that the contracting officer require the Plan to provide evidence or supporting documentation ensuring that the Plan has implemented the necessary corrective actions to improve the netting process and accountability of FEHBP funds (as reported in the audit finding).

Recommendation 5

We recommend that the contracting officer require the Plan to deposit all health benefit refunds and recoveries, including pharmacy and medical drug rebates, into the working capital or investment account within 30 days and return to the LOCA within 60 days after receipt by the Plan.

Plan's Response

HMSA agrees with the finding. HMSA returned the \$162,330 of lost investment income to FEHBP on August 25, 2017. HMSA has not charged the FEHBP for the \$86,604 as we are waiting for the completion of the Office of the Inspector General Audit and OPM permission to do so.

Going forward, HMSA will provide to OPM evidence or supporting documentation that HMSA has implemented the necessary corrective actions to improve the netting process and accountability of FEHBP funds as reported in the audit finding. HMSA will also deposit, as required, all health benefit refunds and recoveries, including pharmacy and medical drug rebates, into the working capital or investment account within 30 days and return to or account for in the LOCA within 60 days after receipt by the Plan.

D. FRAUD AND ABUSE PROGRAM

1. Special Investigations Unit (SIU)

Procedural

HMSA is not in compliance with the communication and reporting requirements for fraud and abuse cases set forth in FEHBP Carrier Letter (CL) 2014-29. Specifically, the Plan did not report, or did not timely report, all fraud and abuse cases to the OIG.

For the period January 1, 2015 through December 31, 2016, the Plan opened [REDACTED] fraud and abuse cases with potential FEHBP exposure. From this universe, we selected and reviewed a judgmental sample of 30 cases for the purpose of determining if the Plan timely reported these cases to the OIG. Based upon our review of these 30 cases, we determined that 28 cases were not reported to the OIG and 2 cases were untimely reported to the OIG.

Plan's Response

HMSA agrees with the statements.

Until the audit, HMSA was not in compliance with communication and reporting requirements as set forth in FEHBP CL 2014-29. Going forward, HMSA will comply with contract and Carrier Letter notification requirements by providing notification to OPM-OIG within 30 working days after determining if there is reportable FWA.

Deleted by the Office of the Inspector General – Not Relevant to the Final Report

HMSA did not enter or track the applicable pharmacy data reported in the 2016 Annual FWA Report, admitting that CVS entered this specific data. HMSA also did not review or verify the data entered by CVS on these reports. As a result, we interpret the comment in the 2016 Annual FWA Report, stating that CVS did not have a FWA Program for the FEHBP pharmacy benefits, as correct.

Plan's Response

HMSA agrees that it did not enter, track, or validate the pharmacy data as set forth in the 2016 Annual FWA Report. In the future, HMSA will enter, track, and validate the pharmacy data as required by CL 2017-13.

Deleted by the Office of the Inspector General – Not Relevant to the Final Report

In the 2016 Annual FWA Report, the data related to the PBM's FWA program cannot be considered accurate if HMSA did not track or verify this data, especially since the PBM did not have a FWA Program. Again, CVS specifically noted that there was no FWA program for the FEHBP pharmacy benefits in 2016. The exclusion of the FEHBP costs, but inclusion of reported recoveries and actual savings, results in the inflation of HMSA's return on investment for FWA. The PBM's data cannot be considered reliable, accurate, or compliant with OPM required reporting.

Plan's Response

HMSA agrees that it did not consistently track or validate the pharmacy data as set forth in the 2016 Annual FWA Report and that the "exclusion of FEHBP pharmacy costs but inclusion of recoveries and savings" could have resulted in the inflation of HMSA's return of investment. In the future, HMSA will accurately enter, track, validate, and report all information as required by CL 2017-13.

CVS does have a [REDACTED]. [REDACTED] These programs are a separately purchasable add-on software program CVS offers its clients. While we agree that the software edits would help identify potential adverse drug interactions or over utilization, we do not believe that the CVS system software edits represent a FWA program.

Plan's Response

HMSA agrees that CVS has a [REDACTED] and these services, along with the [REDACTED], support HMSA's FWA Program. In addition to the data analytic capabilities that assist in identifying potential FWA, these contracted services also provide targeted interventions, pharmacy audit referrals and continuous monitoring. HMSA agrees that these programs alone do not represent a FWA program.

In 2016, all FEHBP Carriers were required to comply with Carrier Letter 2014-29. We noted that HMSA's 2016 Annual FWA Report did not track or report the identified losses, estimated financial losses, and non-recoverable losses, recoveries, savings, and prevented loss for the pharmacy FWA program. Additionally, we question the validity of other CVS reported numbers in the report being FWA related, as HMSA states there was no FWA program for the FEHBP. It is unclear how the data was deemed FWA related, if CVS had no FWA program.

Plan's Response

HMSA agrees that in 2016, all FEHBP carriers were required to comply with CL 2014-20 and that *HMSA's 2016 Annual FWA Report did not track or report the identified losses, estimated financial losses, and non-recoverable losses, recoveries, savings, and prevented loss for the pharmacy FWA program.* In the future, HMSA will accurately enter, track, validate, and report all information as required by CL 2017-13.

HMSA's FWA Process and Procedure Manual does not have PBM oversight and investigative procedures and systematic information for tracking potential FWA leads and/or cases that are received from the PBM.

Plan's Response

HMSA agrees with the statement.

Going forward, HMSA will be refining its processes to meet these requirements and document them in a revised FWA Manual.

HMSA appreciates the opportunity to provide our responses to the Draft Audit Report and request that our comments be included in the Final Audit Report. Thank you for the opportunity to better serve our FEHBP members.

Sincerely,



Executive Vice President, Chief Member Services Officer



Report Fraud, Waste, and Mismanagement

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