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STATE OF HAWAII
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND
HONOLULU, HAWAII

June 23, 2016

ADDENDUM 1

TO

REQUEST FOR PROPOSALS

NO. 16-001

SEALED OFFERS FOR
BENEFIT PLAN AUDIT SERVICES

The following are responses to written questions submitted:

	Question	Answer
1	We note that Segal is serving as consultant to EUTF for purposes of evaluation of Proposals. Will Segal also be allowed to bid on the RFP? If so, can assurances be provided that proprietary information will not be shared with Segal?	Segal is not allowed to submit a proposal in response to this RFP.
2	Please indicate both the home office location as well as the location where the required on-site reviews must take place for each category of audits.	▪ CVS – supports offsite review ▪ CVS Rebate – Chicago, IL ▪ HMSA – Honolulu, HI ▪ Kaiser – Honolulu, HI ▪ HDS – supports offsite review; onsite in Honolulu, HI ▪ VSP – supports offsite review; onsite at Rancho Cordova, CA ▪ Royal State – supports offsite review; onsite in Honolulu, HI ▪ USAble – Honolulu, HI

	Question	Answer
3	On p. 25, there is a reference to COBRA and Premium Conversion Plan participants. Can you advise which plans entitle participants to COBRA and which offer premium conversion? It would be helpful to have additional information on the premium conversion plan.	COBRA participants will be included in the respective active/retiree plan. Premium conversion plans are not included in this RFP.
4	HDS' audit policy on p. 64 seems contradictory. It says both that an onsite visit is not required, but the onsite entrance and exit conferences are required. Please clarify what degree of onsite presence is required.	Discussions with HDS staff will be via teleconference if auditors do not go onsite.
5	Are the Kaiser Retiree Under 65 HMO and Retiree Over 65 Senior Advantage Plan supposed to be combined for purposes of the audit? p. 51 specifies "actives" and "retirees" only; it does not divide retirees into under and over 65.	Yes, all Kaiser retirees are to be included in a combined group with the actives for the eligibility comparison and performance guarantee audit components. However, the Senior Advantage Plan retirees are not included in the other portions of the RFP scope.
6	For purposes of audit planning, can we enlist EUTF's support in scheduling planning meetings to accommodate the TPA's audit policies?	EUTF will assign a representative, along with Segal personnel, to monitor the audit schedules and serve as liaison for required assistance and meetings.
7	Payment to Contractor 1.31. on p. 14 uses the term "review phases" but that reference is not clear when referring to the Fee Exhibit. Are review phases "operational", "eligibility comparison", "electronic comparison", etc.? If not, please clarify.	Invoices may be sent at 4 milestones: ▪ 25% following completion of the data collection, which includes the kick-off meeting, electronic data validation and sampled selections ▪ 40% following completion of the sampled claims review ▪ 25% following release of the draft report for the vendor's review and response ▪ 10% following issuance of the final report to EUTF
8	Has the EUTF been routinely audited and findings acted upon in each of the past 5 years?	Yes, EUTF has external audits every year and has acted on the findings as appropriate.
9	Have the payers of EUTF medical benefits cooperated fully with the audit process, determination of root causes and permanent fixes?	The last HMSA audit was conducted for the period ending June 30, 2006. A copy is attached. EUTF anticipates each vendor will be cooperative with the current RFP project scope.
10	Describe data included in routine medical claim reporting received by EUTF from payers.	Reports vary by vendor and likely do not include the detail required for audit.
11	Number of member inquiries/complaints relating to claims processing received in the latest full fiscal period?	Fiscal year information is not readily available.
12	Number of provider inquiries/complaints relating to claims processing received in the latest full fiscal period?	Fiscal year information is not readily available.
13	What is EUTF's budget for each of the 5 audits?	The budget will not be disclosed.

	Question	Answer
14	G-4. p. 43 states that the prescription drug audit should optimally include "comparison of actual aggregate claim discounts, and dispensing fees to contractual guarantees". However, the pricing grid on p. 50 includes Plan Design Audit and Rebate Audit among the required components. Please indicate whether a pricing audit is required or optional.	Discounts and dispensing fees are a component of the Plan Design Audit with findings compared to discount and dispensing fee guarantees.
15	Regarding the medical audits, do the TPAs allow you to perform a full electronic audit as well as a statistically valid random sample audit for the same time period? Reference: RFP-16-001, page 27 C, D, and E and page 29 Category 2, Electronic Review and Statistically Valid Claim Sample	Yes, see Attachment 6 for carrier audit policies. Total claim counts are a combination of electronic and statistical samples. EUTF anticipates vendors will be open to negotiation of small increases following contract award and disclosure of the auditor's scope of services and sampling methodology.
16	In order to calculate sample size, can you provide the claim counts for the medical plans? Reference: RFP-16-001, page 30, Category 2, Statistically Valid Claim Sample, "Your proposal should clearly indicate the total number of claims to be sampled, with an estimate for the number to be represented in the statistical and target selections."	Refer to Exhibit B for the average covered lives and plan expenditures.
17	The described of the required scope of work for the Category 2 medical plan claim audits (including chiropractic and supplemental coverages) on p. 29 as well as the H-13 of the questionnaire suggest that Royal State's audits should include a random sample. However, the fee proposal form on p. 51 does not include a line for "statistical audit" as do HMSA and Kaiser. Please clarify whether a random sample, statistical audit is required for Royal State and if so, please provide a new Fee Proposal Form for the Royal State Audits.	The "Electronic 100% Audit" anticipates a sample of claims to validate query results. Therefore, costs for the random sample will be included on this line. The statistical audit measures overall performance levels without sampling bias. Should the Offeror's proposed scope include statistical sampling for Royal State, HDS, VSP or life insurance, such sampling methodology should be defined in the response to questions and included in the "Electronic 100% Audit" line of the Fee Proposal Form.
18	On page 6 (Second and third full paragraphs) of the RFP, its states that proposals "shall be mailed or hand delivered." For compliance with the proposal labeling identified in this section, can you clarify whether delivery by a courier such as Fedex/UPS is considered a hand delivery?	Delivery by FedEx/UPS is considered hand delivery.
19	Page 21, second bullet, states we must provide "audited financial statements." As a certified public accounting firm, we do not have audited financial statements. Will the EUTF accept internally-prepared financial statements?	Yes, if submitted with a notarized attestation of the accuracy of information provided.
20	General: What firm/vendor performed the most recent Prescription Drug Plan audit?	The Segal Company.

	Question	Answer
21	General: What were the fees for the most recent Prescription Drug Plan audit?	$80,000 including travel expenses. The audit commissioned in March 2015 had a slightly different scope of services from those in listed in RFP 16-001.
22	General: What budget has been established for the current requested Prescription Drug Plan audit?	The budget will not be disclosed.
23	General: Why is the current Prescription Drug Plan audit limited to only one period of review?	The subsequent contract period contains a provision for the vendor to engage an auditor.
24	General: Are future periods of Prescription Drug Plan review planned but not currently requested as part of this RFP?	Yes.
25	General: Is the Prescription Drug Plan rebate structured so that EUTF receives a guaranteed standard dollar amount per paid prescription claim (i.e. $10 for each Brand Name retail prescription, $30 for each Brand Name mail order prescription), or is the rebate structure a 100% pass-through payment of rebates? If it is some other arrangement can you provide some detail on the rebate structure?	Rebates are the greater of the guaranteed rebate or the pass through amount.
26	Has EUTF intentionally not included Period 5 in the fee proposal form for the following audits: Medical --Kaiser Supplemental Medical--Royal State Dental--HDS Vision--VSP	Yes.
27	RFP page 2; Paragraph 6; Line 1 *The Fee Proposal Form(s) included in the RFP (Section VII) shall be used for all cost information; any other format will not be accepted.* • Should the Fee Proposal Forms be completed as a separate Word document and bound/packaged on their own? Or should the Fee Proposal be included as part of the overall response to the RFP Questionnaire? • If the Fee Proposal should be separately packaged, please provide proposal submission instructions regarding the number of hard copies, number of electronic copies, packaging instructions, etc.	See Proposal Instructions on page 15; the Fee Proposal is to be included as one proposal.

	Question	Answer
28	RFP page 25; Paragraph 2, all lines (*Category 1 Prescription Drug Plans)*; Paragraph 3, all lines (*Category 2 Medical Plans)* • The Prescription Drug and Medical plans manage multiple groups (Active, Retiree, Retiree Under 65, Retiree Over 65). We assume that the data for all groups will be provided in the same format. Can you confirm? • If it will not all be provided in the same format, please detail how it will be provided.	Each vendor has their own data layout. There should be no vendor difference based on the eligibility classification.
29	RFP page 25; Paragraph 3 (Category 2 Medical Plans); Lines 1-9 (all lines) • For each Medical Plan included in the RFP, how many plan variations will be audited? For example, within each plan are there varying deductible and out-of-pocket amounts for different populations? • In the Medical Plans, Active Medical and Prescription Drug Supplemental, Active Chiropractic, and Retiree Chiropractic (HSTA VB only) are carved out to Royal State. Please describe how the Royal State data integrates with the claims from the HMSA and Kaiser Medical Plans.	A description of the current benefits can be found on EUTF's website http://eutf.hawaii.gov. There is no integration. The Royal State plan merely reimburses copayment and deductibles once a receipt from the member is presented.
30	RFP page 30; Paragraph 1; Fifth bullet on page 30 - *Benefit limitations, deductibles, copays, coinsurance, and out-of-pocket maximums were properly applied* • Is there any out-of-pocket or deductible carryover from previous plan periods? • Do any other claim types outside of the audit scope accumulate toward the deductible or out-of-pocket amounts?	A description of the current benefits can be found on EUTF's website http://eutf.hawaii.gov.
31	RFP pages 73-74 (Exhibit B); Tables 2a, 2b, and 2c on each page; Line 1 of each table • As detailed throughout the tables in Exhibit B, benefit plans include fully insured data. When it comes to fully insured data, Carriers can limit the data they are willing to provide. Will we be able to negotiate with your Carriers to ensure we get all the data necessary to conduct comprehensive audits?	Yes.
32	General: Our understanding is that eligibility data will be provided by EUTF and not by each carrier/vendor. Can you confirm?	Correct, information can also be requested from the carrier/vendor.

	Question	Answer
33	General • Have previous audits of the benefit plans been conducted? • If so, will copies of the prior audit reports be made available?	▪ A pharmacy audit was conducted for the period ending June 2013. A copy will be made available to the selected Offeror. ▪ The last HMSA audit was for the period ending June 30, 2006. A copy is attached. ▪ No prior audits were conducted for the remaining benefits/vendors.
34	For the unbound master report, is there a preference between loose/binder clip and put loose into a ring binder? (p. 6)	The unbound master should not contain hole punches.
35	Is there a preference with regards to the use subcontractors? I know that some organizations would prefer to not have functions subcontracted out. The reason that I ask is that we have a subcontracting partner with regards to pharmacy audits. It sounds like they can bid on pharmacy and we can bid on the remaining (i.e. two independent bids) thus eliminating the need to subcontract. (p. 16)	The Offeror is responsible for all work products. Therefore, the use of subcontractors is at the Offeror's discretion but the subcontractor must meet all of the experience qualifications contained in the RFP. If the pharmacy audit subcontractor wishes to submit a proposal directly, it must meet all of the requirements and qualifications independently.
36	In the Audit Plan Design component of scoring, does EUTF require/prefer a copy of our audit plan? Or is an explanation of our tests and processes sufficient? (p. 21)	Responses to questions A.1 through I.13 will be scored. Concise responses should include the elements that distinguish your proposed audit services.
37	Is it okay to bid on some but not all of the audits? If so, would we just indicate such in the fee section by not completing the relevant audits? (p. 25)	Yes to both questions. Although EUTF anticipates that vendors proposing Category 2 (medical plans) will also find cross-over to Categories 3 through 5.
38	This question relates to the 100% electronic review (p. 29): a. What is the intended use of the output related to the 100% audits? Compliance? Monitoring? Collection of potential overpayments? It has been our experience that attempting to collect overpayments based the results of 100% audits tends to have a lot of scrutiny due to the lack of actual claims testing. b. For approved benefits, is there a listing of the applicable allowable procedure codes, DRG codes, APC, SNF, drugs, etc.? c. Is there a listing of non-allowed codes? d. For appropriate patient cost shares, is it the intention that the 100% audit aggregate each member's accumulators relative the member maximum in order to determine whether cost share should continue to be applied (and how much applied)?	a. Compliance with plan provisions. b. No; to be discussed with the vendor(s) after award. c. No; to be discussed with the vendor(s) after award. d. Patient cost shares (copay, deductible, coinsurance) vary by type of service; review should identify under and overpayments on claim level and aggregate. Proposals should disclose your audit capabilities. e. To be discussed with the vendor(s) after award. f. To be discussed with the vendor(s) after award.

	Question	Answer
	e. For coordination of benefits, is there a listing that can be provided of members that have other insurance (Medicare, etc.)? f. For coordination of benefits, is there a listing that can be provided of members where a subrogation case has been opened for further review (worker's comp, car accident, etc.)?	
39	This question relates to the targeted samples (p. 29): a. Is it EUTF's intention to use the targeted claims as a verification mechanism of the 100% audit results? b. Does EUTF expect a targeted sample related to each of the 5 100% audits? c. Does EUTF have an anticipated/desired sample size for validating the 100% audits?	a. Yes b. Yes c. No
40	This question relates to the statistically valid claim sample (p. 29-30): a. It mentions 95% confidence level. What is the desired level of precision? It is necessary to have both of these items to determine an SVS using the attributes sampling methodology. b. Please further clarify what is desired related to the testing of administrative procedures. Are these claims processing procedures? c. With regards to the timeliness of claims processing (unnecessary processing delays), would EUTF be willing to consider performance of a monthly or 100% analysis as it relates to timely payment and prompt payment laws? d. With regards to the duplicate payments, would EUTF be willing to consider using a query of more susceptible claims and then targeted sampling using judgment?	a. EUTF understands the vendor's maximum sample size will impact each audit firm's level of precision. b. Yes c. Offeror should recommend their reliable option. d. The expectation is that all suspect duplicates will be identified with a target sample using auditor judgment.
41	What type of test does EUTF desire related to the evaluation of staffing levels and experience (F-3 p. 39)? Inquiry of hiring/employment policies? Some kind of ratio/analytical preferred?	Refer to the Operational Review beginning on the bottom of page 26 for the expected evaluation points. Offerors should identify any additional aspects they feel meet the EUTF's objectives.
42	What types of administrative policies does EUTF consider as applicable for the contractual obligations (F-10 p. 41)? Claims processing?	Refer to the Operational Review beginning on the bottom of page 26 for the expected evaluation points. Offerors should identify any

	Question	Answer
	Admin policies related to the PGs with the TPA?	additional aspects they feel meet the EUTF's objectives.
43	For security breaches, is it EUTF's intention for us to review the TPAs documentation and internal testing or for us to perform independent testing related to known/possible security breaches (F-12, p. 42)?	Independent testing is not anticipated but can be included at the Offeror's discretion.
44	For evaluation of the automated system, does EUTF expect the auditor to perform an independent testing/vouching of the processes (H-18, p. 47)? Or is inquiry of the TPA sufficient? It would be unusual for a TPA to provide a claims auditor with access to system level controls for verification/validation purposes.	Independent testing is not anticipated but can be included at the Offeror's discretion.
45	For accuracy of total out of pocket expenses, is it sufficient to perform OOP maximums testing on the claims sample (I-5, p. 47)?	The Electronic Review should also include this patient cost share.
46	Regarding denied and pended claims, what knowledge/testing would EUTF like to get (I-7 p. 47)? Causation? Accuracy of denial? Reason for pend? Will this be as of the date tested for pended claims (i.e. something may be pended when selected but then processed before testing)?	Offeror processes may differ. The EUTF wants to ensure claims are not pended or denied when the information is available for processing.
47	Do you desire independent samples for active and retirees? Or is one sample from a population consisting of both types sufficient (p. 51)?	Offeror's choice.
48	When a timeframe spans more than one year, like with chiropractic, do you desire separate samples for each plan year or one sample from a population containing all dates (p. 52)?	Offeror's choice.
49	Multiple vendors limit the sample sizes (i.e. 200 claims for HMSA). Some questions regarding this (p. 63): a. Is that any and all samples including targeted and random? b. Some of the allowable samples sizes may not be sufficient for the auditor to guarantee 95% confidence. How should the auditor handle this scenario should it be applicable? c. When given a limit per onsite, how should this be considered if there are multiple benefit types (active vs retiree) or spans multiple plan years (if separate samples are desired)?	a. Yes. b. Clearly identify why 95% confidence is not expected. c. Response varies by vendor. Offeror should clearly identify their methodology.

Attachment for Nos. 9 + 33

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

HMSA
BLUE CROSS BLUE SHIELD OF HAWAII

ANALYSIS AND EVALUATION OF CLAIMS PROCESSING AND PAYMENT PROCEDURES

FOR THE PERIOD
JULY 1, 2005
THROUGH
JUNE 30, 2006

PRESENTED
MARCH 30, 2007

SUBMITTED BY:

THE SEGAL COMPANY
CLAIMS AUDIT DIVISION
1230 W. WASHINGTON STREET
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CONFIDENTIALITY STATEMENT

Release of electronic and hardcopy information required for this analysis required execution of an agreement signed by The Segal Company and Hawaii Medical Service Association (HMSA).

All audit information and findings prepared and presented in this report are considered confidential and proprietary. Sharing of contents with any other party, or the copying of information herein, is expressly prohibited without the written consent of the agreeing parties.

TABLE OF CONTENTS

PAGE

SECTION I – SUMMARY 1
- ADMINISTRATIVE PROCEDURES 2
- CLAIMS AUDIT RESULTS – STRATIFIED SAMPLE 2
- ZERO PAYMENT TARGET SELECTION 3
- PRESCRIPTION DRUG TARGET SELECTION 3
- ELIGIBILITY REVIEWS 4
- ELECTRONIC CLAIMS ANALYSES 4
- SYSTEM TESTING 4
- COMMENTS AND RECOMMENDATIONS 5

SECTION II – CLAIMS ADMINISTRATION REVIEW 8
- ADMINISTRATIVE PROCEDURES REVIEWED 8
- ADMINISTRATIVE SERVICES 9
  - VENDOR OUTSOURCING 9
  - CLAIMS EXAMINERS 10
  - CUSTOMER SERVICE REPRESENTATIVES 10
- CALL CENTER OPERATIONS 11
- ADMINISTRATIVE CONTROL STANDARDS 12
  - INTERNAL AUDITS 12
  - PERFORMANCE MEASUREMENTS 12
- ENROLLMENT AND ELIGIBILITY 13
  - DATA RECEIPT/UPDATES 13
  - RETROACTIVE TERMINATIONS 13
  - COBRA NOTIFICATION/ADMINISTRATION 13
- CLAIMS HANDLING SYSTEM 13
- PROCESSING GUIDELINES 14
  - REFERENCE MATERIAL 14
  - COORDINATION OF BENEFITS 14
  - WORKERS' COMPENSATION AND THIRD PARTY LIABILITY 14
  - BLUE CARD CLAIMS/OUT-OF-POCKET CALCULATION 15
  - INTERIM HOSPITAL BILLINGS 15
- COMMUNICATIONS TO PROVIDERS AND PARTICIPANTS 16
  - REQUESTS FOR CLAIM INFORMATION 16
  - APPEAL PROCESS 16

PROVIDER FILES AND MAINTENANCE OF FEE SCHEDULES 17
PROVIDER MAINTENANCE 17
NETWORK FEE SCHEDULES 17
OUT-OF NETWORK FEE SCHEDULES 17
CLAIM CONTROL MEASURES 18
FINANCIAL ACCOUNTING 19
PREMIUM PAYMENTS AND RECONCILIATION 19
OVERPAYMENT RECOVERY 19
CLAIMS PROCESSING SYSTEM 19
SYSTEM SECURITY 19
POWER FAILURE/DISASTER RECOVERY 20
SUMMARY OBSERVATIONS 20
SECTION III – CLAIMS AUDIT REVIEW 22
SELECTION OF CLAIMS 23
DETERMINATION OF ERRORS 23
STRATIFIED SAMPLE PROCESSING ACCURACY 23
SUMMARY OF ERRORS 24
TURNAROUND TIME – STRATIFIED SAMPLE 24
ZERO PAYMENT TARGET SELECTION 25
TARGET PRESCRIPTION CLAIMS SELECTION 25
EXHIBIT A – ERROR LISTING 27
EXHIBIT B – TURNAROUND TIME – SAMPLE ANALYSIS 28
EXHIBIT C – STRATIFICATION TABLE 29
SECTION IV – ELIGIBILITY REVIEWS 30
EUTF AND HMSA RECORD COMPARISON 30
HMSA ELIGIBILITY AND CLAIMS COMPARISON 30
OVERAGE DEPENDENTS 31
TARGET ELIGIBILITY TRANSACTION 32
SECTION V – ELECTRONIC CLAIMS ANALYSES 33
POTENTIAL DUPLICATE PAYMENTS 33
STANDARD PROCEDURE CODES 34
ELECTRONIC TURNAROUND TIME ANALYSIS 34
SECTION VI – SYSTEM TESTING 35
SECTION VII – RESPONSE TO DRAFT REPORT 38

This report analyzes and evaluates claims processing and payment procedures utilized by Hawaii Medical Service Association Blue Cross Blue Shield of Hawaii (HMSA) in the administration of the Hawaii Employer-Union Health Benefits Trust Fund's (EUTF) group benefits. Ms. Carol Hoel, Ms. Lynda Sheldon, and Ms. MaryAnne Watson conducted the onsite review at HMSA's Honolulu, Hawaii claims office from December 4 through December 12, 2006. In accordance with Segal's proposed services, the scope of our medical plan audit included the following review components:

- Administrative Procedures
  - HMSA's written responses to Segal's questionnaire
  - onsite discussions and observations
  - sample records and/or reports review
- Individual Claims Audit
  - 210 stratified sample of claims processed during the period July 1, 2005 through June 30, 2006
  - 15 target zero payment claims to verify accuracy of denials and deductible application
  - 25 target prescription claims selected following 100% data analysis
- Eligibility Reviews
  - EUTF and HMSA eligibility records comparison
  - HMSA eligibility records vs. claim payments
  - overage dependents
  - 15 target eligibility transactions
- Electronic Claims Analyses
  - potential duplicate payments
  - industry standard procedure codes
  - quarterly turnaround time
- System Testing
  - unique benefit provisions
  - industry standard edits
  - system exceptions/examiner override

HMSA provided electronic data files of eligibility records and claims processed during the period January 1, 2005 through June 30, 2006 for our claims sampling and electronic analyses. The audit period was July 1, 2005 through June 30, 2006; however, data for expanded dates was required to perform our electronic duplicate analysis.

A total of 1,621,316 claims, representing $227,222,383.52 in benefit payments, were paid during the period July 1, 2005 through June 30, 2006. HMSA redacted personally identifiable information on claims with mental health and HIV diagnoses, stating release is restricted by State law; this represented 67,359 claims (4.15%) totaling $8,465,166.09 (3.73%). Due to limited data fields, these claims were excluded from our duplicate analysis and electronic eligibility reviews.

ADMINISTRATIVE PROCEDURES

Our comprehensive review began with HMSA's responses to our written questionnaire. Processes were confirmed through onsite discussions with appropriate HMSA staff, department walk-through observations, and individual claims review. Further documentation was reviewed for the following processes.

- Customer service call records and monitoring
- Subrogation/third party liability (TPL) logs
- Medical case management
- Hospital audit guidelines
- Appeal records
- Security violations

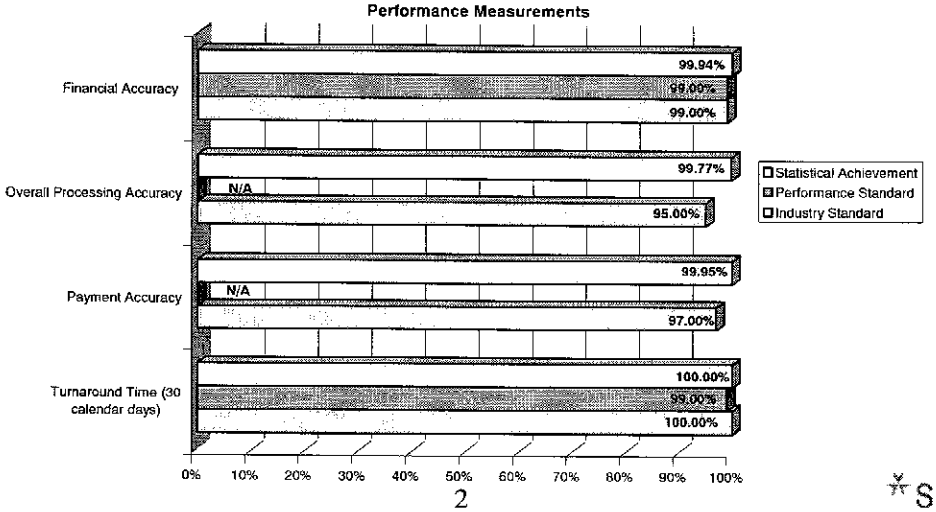
Our review confirmed the effectiveness of HMSA's internal procedures (*e.g.,* responsiveness, investigation, tracking, and reporting) for the above administrative functions based on industry best practices. Segal's extended review process and findings are detailed in Section II; Summary Observations on pages 20 and 21 are offered to assist EUTF in identifying procedures that may require review or change in their transition to a self-funding arrangement.

CLAIMS AUDIT RESULTS – STRATIFIED SAMPLE

Benefit payments on behalf of eligible employees, retirees and their dependents totaled $227,222,383.52 during the audit period July 1, 2005 through June 30, 2006. Our analysis of 210 stratified claims represents benefit payments totaling $4,763,615.24.

The auditors completed a form for each claim selected in the sample; this worksheet was the primary documentation on which our report is based. Due to the confidentiality of names, diagnosis, etc., claims addressed within this report are referred to as "Worksheets."

A recap of the accuracy rates achieved by HMSA during the twelve-month audit period follows. Based on the statistical analysis, HMSA exceeded performance standards for the accuracy of benefits and processing timeliness. Industry standards are included for comparison.



Industry standards are developed through ongoing review and comparison of measures utilized by major carriers and third party administrators nationwide. Standards include acceptable performance for administration of fully-insured and self-insured corporate, public, and multi-employer plan benefits.

Detailed descriptions of the audit findings are presented in Section III. The dollar amount of five payment errors totaled $1,014.47 (one overpayment of $240.00; four underpayments for $774.47); two procedural errors were identified. Our review of related patient claims histories identified three potential or confirmed file payment errors totaling $83,546.02; two overpayments for $83,417.86 and one underpayment of $128.16. These are classified as "other claim matters" and excluded from our statistical analysis. Exhibit A details all errors identified during our review of the 210 stratified sample.

Based on our claims sample, HMSA met performance guarantees for processing 99% of Non-Investigative Claims within 30 calendar days. A detailed analysis of claims processing turnaround time is presented as Exhibit B.

ZERO PAYMENT TARGET SELECTION

An additional 15 zero payment claims were sampled to ensure accuracy of denials and deductible application; our review revealed each was correctly processed. Due to sample size requirements, these claims are treated as a target sample and not included in our stratified sample or factored into the statistical achievement calculations.

PRESCRIPTION DRUG TARGET SELECTION

Our prescription plan analysis included the following two processes to determine whether the claims were adjudicated according to contractual performance standards, appropriate Plan benefits, and industry standards.

- Electronic in-house analysis of all transactions and rebates due the Plan
- Onsite review of 25 target claims to validate results of the electronic analysis for potential exceptions (*i.e.*, copay discrepancies, excluded diagnoses, etc.)

One overpayment ($2,897.11) was assessed for benefits paid without required prior authorization. Other potential discrepancies were explained through review of system status codes and claims adjudicated as secondary payor under coordination of benefits (COB). Details of our sample review are included in Section III.

Based on further discussions with HMSA, and observations during our target sample review, Segal's original electronic query process was refined for a second analysis. Results will be submitted under separate report cover.

ELIGIBILITY REVIEWS

EUTF provided a data file of eligibility for the audit period in addition to 15 target transactions for review. HMSA was unable to identify one member under the target sample; follow-up by Segal's auditors with EUTF confirmed the member is enrolled under the Kaiser HMO option.

Our comparison of HMSA's eligibility and claims data identified benefit payments totaling $391,024.18 for services rendered after the patient's termination date. HMSA states they have an agreement with EUTF to accept retroactive terminations; however, they do not pursue overpayment recovery.

Details of our review processes and findings are included in Section IV. The results of our electronic analyses and sample transactions offer a level of confidence in HMSA's overall record accuracy; however, the scope of our review does not provide a complete eligibility reconciliation. Segal will provide the complete list of file discrepancies under separate cover should EUTF decide to perform an in-depth reconciliation.

ELECTRONIC CLAIMS ANALYSES

The following electronic analyses were performed using claims data provided by HMSA. Our review process and detailed findings are included in Section V.

- *Duplicate Payment Analysis:* Our preliminary analysis identified potential duplicates totaling approximately 4.30% of benefits paid July 1, 2005 through June 30, 2006. Onsite sample review by Segal auditors and additional research by HMSA provided explanation that most claims were not duplicate payments. A list of those still identified as potential overpayments was provided to HMSA for further review and corrective action, as appropriate.
- *Industry Standard Procedure Codes*: HMSA accepts only industry standard codes on claim submissions; however, some codes are converted to an internally developed code format required for the system to recognize and administer benefits that are unique to a particular plan or benefit type. The standard coding is retained for report use or electronic data exchange.
- *Turnaround Time Analysis*: HMSA's performance guarantee is based on Non-Investigative Claims; the requirement is 99.0% processed within 30 calendar days. Our results are based on all claims processed in the audit period; we were unable to track multiple transaction dates on a single claim (*i.e.*, pend responses or adjustments). Our quarterly results, provided for comparative purposes, indicate HMSA met performance guarantees for two of the four quarters.

SYSTEM TESTING

HMSA assigned a system analyst to assist in our review of the benefit program elements. Segal's auditor identified specific Plan provisions (*i.e.*, deductibles, coinsurance levels, maximums, and limitations, etc.) in addition to standard edits or processes (*i.e.*, gender or age specific procedures, multiple surgery calculations, eligibility, etc.) for testing. Our review confirmed accurate benefit mapping and extensive software edit capabilities are in place to

prompt examiner review and manual override action, as appropriate. Details of our testing process and findings are presented in Section VI.

COMMENTS AND RECOMMENDATIONS

An analysis of HMSA's administrative procedures is provided in Section II. HMSA was presented with a draft report on January 31, 2007 for their review and comment. Their formal written response was received February 16th, and is included in Section VII. As appropriate, responses have been paraphrased and noted below in italics with Segal's comments included.

Details of each comment and/or recommendation are provided in Sections II through VI. The following suggestions are offered for improving accuracy levels and concerns identified in this report:

- Overpayment recovery fees (33.33% or 50%) are greater than we normally observe; 17% to 30% is a more standard range. Recovery from network providers reduces the potential need for collection services; however, EUTF should confirm any changes to vendor fees under their self-funding arrangement. (VENDOR OUTSOURCING, PAGES 9 AMD 10)

  HMSA states recovery outsourcing is their last resort after all internal resources (internal refund request protocol or legal action) have been exhausted, and therefore not frequently used. When EUTF has a self-funded arrangement, they will have the discretion of using this collection agency or choosing another.

- HMSA should investigate a system enhancement to facilitate after-hour messages for expanded caller access. (CALL CENTER OPERATIONS, PAGE 11)

  HMSA reports dedicated after-hours message service is technically feasible should EUTF express an interest.

- Based on industry standards, EUTF should consider increasing their contract guarantees for turnaround time to 95% within 14 calendar days. They should also consider initiating a 97% performance guarantee, with monetary penalty, for Payment Accuracy to further enhance claim control measures. (PERFORMANCE MEASUREMENTS, PAGE 12)

- In consideration of the Plan's change to a self-funding arrangement effective July 2007, HMSA and EUTF should discuss implementation of a look-back period and dollar threshold to pursue overpayments for retroactive terminations. (RETROACTIVE TERMINATIONS, PAGE 13; HMSA ELIGIBILITY AND CLAIMS COMPARISON, PAGES 30 AND 31)

  Looking forward to EUTF's self-funded arrangement, HMSA and EUTF will work together to identify a process to address retroactive terminations.

- EUTF should consider establishing annual requests for COB information on a 12-month rolling basis with mandatory employee response requirements to ensure industry best practice is followed once self-insured. (COORDINATION OF BENEFITS, PAGE 14)

HMSA supports this recommendation; COB information is not received on the enrollment file submitted by EUTF.

Segal notes industry practice varies for method of request (by employer or claims administrator); however, responses are normally returned to the claims office for system entry of all other insurance information, including name of other plan, family members covered, type of coverage, and effective or termination dates. The enrollment file would not be expected to provide the level of COB detail required for order of benefit determination.

- HMSA should implement procedures to update the member's calendar year out-of-pocket when a Blue Card (out-of-state) claim is originally processed to prevent excess member liability. (BLUE CARD CLAIMS/OUT-OF-POCKET CALCULATION, PAGE 15)

The BlueCard Program allows members to receive services from the Blue Network at a discount, which result in substantial savings to EUTF. A delay in updating the member's claims history and associated co-pay/co-insurance accumulators is an inherent risk in the BlueCard program. We will look for ways to reduce the lag time in posting out-of-area claims.

Segal has audited a number of state and regional BlueCross BlueShield licensees that participate in the national BlueCard Program without observing this out-of-pocket problem. Claim procedures and/or system capabilities allowed other entities to finalize the claim processing, including application of appropriate accumulators, with subsequent update of check release by the Host plan.

- HMSA and EUTF should discuss procedures for advance and ongoing notification of pending large dollar hospital claims to ensure management reports and advance funding considerations are addressed under the Fund's upcoming self-funding arrangement. (INTERIM HOSPITAL BILLINGS, PAGE 15)

In preparation for when EUTF has a self-funded arrangement, HMSA can discuss procedures so that hospitals will provide advance and ongoing notifications.

Segal concurs that advance hospital notification is appropriate; this is normally obtained through a certification or authorization process. Our recommendation was specifically directed to HMSA's notification of interim bills received for extended confinements where additional expenses are expected. HMSA does not calculate or release benefits until a final bill is submitted; our audit sample included four long term inpatient confinements with multiple interim billings.

- HMSA should extend their $100.00 minimum recovery threshold to suspected fraud and duplicate payments; reduction through current benefits payable should be considered for refusal or non-response to refund requests. (OVERPAYMENT RECOVERY, PAGE 19)

It appears Segal misinterpreted HMSA's written explanation of refund procedures and dollar threshold. The $100.00 threshold is already in place for all payment errors, including suspected fraud and duplicate payments. Anything under the $100.00 threshold may be pursued at management's discretion.

Segal acknowledges HMSA's corrective response. We continue to recommend that HMSA reclaim all overpayments from future claim benefits if a provider or member refuses refund.

- EUTF should consider a system parameters review to confirm benefit design accuracy on HMSA's new system prior to or immediately following live claims processing. (CLAIM PROCESSING SYSTEM, PAGE 19)

  Accuracy of the benefit design is reviewed by operations and continuously monitored by internal audits. It is at EUTF's discretion to consider a system parameters review.

- Underpayments identified in this review should be reopened and additional payment sent to the member and/or provider with explanation. Overpayment recovery should be initiated based on HMSA's $100.00 threshold. (EXHIBIT A, PAGE 27)

  HMSA is in the process of correcting the underpayments and overpayments identified in the review based on internal guidelines.

- HMSA should advise EUTF of confirmed duplicates based on findings of Segal's electronic analysis and onsite review; overpayment recoveries should be implemented per HMSA's internal procedures. (POTENTIAL DUPLICATE PAYMENTS, PAGE 33)

  HMSA is continuing analysis of the potential duplicate findings.

- HMSA should define allergy test series codes for the processing system to identify and deny services that exceed the Plan's annual maximum (*e.g.*, one series of tests per year). (SYSTEM TESTING, PAGE 35)

  HMSA will analyze the benefit of a front-end edit check versus a back-end review for the allergy test series codes.

  Segal requested clarification of back-end review procedures as this was not indicated during the onsite system testing. HMSA expanded their response to indicate logic could be developed to identify these situations.

- EUTF should consider a follow-up audit within six months from the group's transition to a self-funded arrangement to ensure consistency and accuracy of administrative services.

- HMSA should advise EUTF of any change in procedures resulting from this review as well as resolution of the payment errors addressed in this report

  HMSA will inform EUTF of final resolutions for the identified payment errors.

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This report would be incomplete without recognition of the assistance and cooperation extended to us by HMSA personnel in preparing for this project and during the onsite phase of our review. Their commitment of service to EUTF was evidenced throughout the entire audit process.

Our review included an analysis of day-to-day processing procedures utilized by HMSA's Honolulu, Hawaii claims office in its administration of EUTF group health claims. To expedite this review, a questionnaire identifying specific areas was sent to HMSA for completion prior to the onsite visit. Their written reply, onsite discussions, and responses to specific claims in review enabled us to evaluate the control measures in place for efficient adjudication of Plan benefits.

ADMINISTRATIVE PROCEDURES REVIEWED

This review focused on general and Plan specific administrative procedures established for processing claims from initial receipt in the mailroom through final disposition (*i.e.,* check issuance or denial).

- Claims Administrative Services
  - any outsourced administrative functions
  - division of responsibilities established for effective claims handling
  - experience (industry, company, or plan) of staff assigned to the Plan
  - training of new examiners or customer service representatives and continued educational programs
- Call Center Operations
  - customer service access and response
  - call monitoring
  - tracking and reporting mechanism
- Administrative Quality Controls
  - internal claims audits
  - performance measures
  - processing timeliness
- Enrollment and Eligibility
  - receipt of eligibility data from EUTF (*i.e.*, initial enrollment, additions, terminations, and dependent status)
  - timeliness of updates to the claims adjudication system
  - Consolidated Omnibus Budget Reduction Act (COBRA) administration
- Claims Handling System
  - receipt, opening, sorting of mail
  - electronic submissions (*i.e.*, provider and facility, documentation, etc.)
  - input, scanning, and distribution
  - storage and retrieval of claims documentation

- Processing Guidelines
  - reference materials available to examiners
  - claims submission
  - procedures and guidelines used in the adjudication of claims
  - coordination of benefits
  - workers' compensation and third party liability (subrogation)
  - on-the-job injuries/illnesses

- Communications to Providers and Participants
  - requests for additional information and follow-up procedures
  - denial and appeal procedures

- Fee Schedules and Provider Files
  - determination and updates to maximum allowable charge (MAC)
  - additions and deletions to provider records
  - identification of participating providers and appropriate fee schedules

- Claim Control Measures
  - fraud detection
  - hospital bill audits
  - pre-certification/utilization review
  - large case management
  - wellness programs/disease management

- Financial Accounting
  - contribution/premium reports
  - reconciliation process
  - recovery of overpaid claims

- Processing System
  - duplicate payment and unbundling edits
  - auto-adjudication
  - personnel access and authority levels
  - system recovery plan

Outlined below are certain administrative aspects and processing procedures identified in HMSA's response to Segal's questionnaire, and through onsite observations and discussions; comments are offered as appropriate to each topic.

ADMINISTRATIVE SERVICES

Vendor Outsourcing

HMSA provides all administrative functions in-house with the exception of the following specialty services:

- Disease Management – American Healthways

- Coordination of Behavioral Health Services – APS Healthcare, Inc.
- Outstanding Overpayment Recoveries – Pacific Collections

American Healthways and APS Healthcare service fees are contracted on a per participating member per month basis. Pacific Collections retains 33.33% of recoveries; the fee increases to 50% for out-of-state providers or cases requiring litigation. Recovery from network providers, following 30 days notice of intent, reduces the potential need for collection services; however, 33.33% or 50% is greater than we normally observe. Segal recommends EUTF confirm any changes to vendor fees under their self-funding arrangement.

Vendor services are monitored for effectiveness through various measures, including clinical process/outcome, financial savings, disease management program reports, monthly quality and operations meetings, and provider/member satisfaction surveys.

Claims Examiners

Currently, 105 examiners process EUTF claims approximately 25% of their time; average examiner experience ranges from six to twelve years. HMSA reports a 14.4% turnover rate in the claims administration department for the period July 1, 2005 through June 30, 2006; this is similar to the overall company average of 14.75% for the same period.

Newly hired examiners receive four to six weeks system functionality training (one-on-one and in a classroom setting) under the instruction of quality assurance trainers and senior level examiners. Claims processing training extends over several months beginning with entry level adjudication and expands to include intermediate and complex benefit adjudication. As training progresses, new examiners are subject to 100% audit until they attain 98% or better accuracy.

Claims examiners are not specifically assigned to EUTF's account, but are organized into units that are specific to claim type (*e.g.,* hospital or professional). Assignments within units are based on specialization for coordination of benefits or third party liability, claims adjustments, and out-of-area (Blue Card) charges. Further claim division is dependent on system edit reasons (*i.e.*, eligibility, duplicate, anesthesia, etc.) requiring examiner review.

Customer Service Representatives

Customer service functions are performed within a separate department with division of assignments based on HMSA's lines of business. HMSA maintains a separate department of 38 customer service representatives (CSRs), with experience ranging from six months to twenty years, who devote approximately 5.5% to 16.7% of their time servicing EUTF member or provider inquiries. HMSA reports the turnover rate was 28.03% for the period July 1, 2005 through June 30, 2006; this is slightly higher than the 25.98% average turnover rate for the preceding five-year period.

All CSRs are first trained on the EUTF Group and Individual lines of business, which are very similar plans. New hire training begins with an eight-week classroom course on benefits, eligibility, reading processed claim payments, navigating the system, and resources available for their use; they also listen in on live calls with experienced CSRs to hear how various calls are

handled. Skill and knowledge development is tested by participation in call simulations throughout the training period. After satisfactory testing on all training aspects, new CSRs receive an additional two weeks on-the-job training in which they answer calls with a mentor in attendance.

Staff members in other departments (*i.e.*, mailroom, scanning, data entry, and system support) also provide on-going account services. HMSA conducts background checks on all prospective employees prior to offer of employment.

CALL CENTER OPERATIONS

HMSA maintains seven physical call center locations; one in Kauai, one in Maui, two on Oahu, and three on the island of Hawaii; however, call routing is invisible to the caller. Two toll-free numbers are available: one for neighbor island members to call Oahu and another for Molokai/Lanai to Maui. Call centers operate from 8:00 a.m. to 4:00 p.m., Monday through Friday; after-hours messaging services are not available. HMSA's lack of after-hour messaging services is uncommon within the industry. Segal recommends HMSA investigate a system enhancement to facilitate after-hour messages for expanded caller access.

Calls are answered on the first ring by an automated service that provides the caller with menu selections; calls are then routed to the appropriate CSR. At that point, the system automatically tracks call statistics with HMSA reporting 79.9% of calls are handled on first contact. CSRs complete inquiries for calls requiring additional action (*i.e.*, referral for claim adjustment, or research through another department); the system tracks outstanding inquiries not resolved within 24 hours. CSRs are responsible for inter-department follow-up and caller notification, as necessary.

Internal goals for telephone service are speed of answer within 30 seconds and call abandonment of 5% or less. Quarterly reports are provided to the national BlueCross BlueShield Association (BCBSA); results are not client specific. Four calls per month for each CSR are monitored to measure individual quality of service.

To validate call monitoring and tracking processes, Segal reviewed a sample of the following HMSA reports for April through June 2006:

- Call monitoring log with scoring guidelines and documentation of evaluation criteria
- System call records with date, number of calls, speed, abandonment, and duration

Industry standards for call tracking and monitoring were supported through review of sample reports, onsite discussions, HMSA's written procedures, evaluation criteria, and record data.

ADMINISTRATIVE CONTROL STANDARDS

Internal Audits

HMSA monitors claims accuracy through two performance measurements; Member Touchpoint Measures (MTM) and Claims Administration (CA) audits. MTM involves a stratified selection process, while CA audits are performed on a random selection of each examiner's production.

Six analysts support the audit function for the MTM unit; all claims administration analysts complete specialized training and are assigned based on experience. MTM performs weekly audits from the claims population, which is divided into three dollar strata. Their findings are reflected in quarterly reporting of EUTF claims accuracy performance. Results are also reported to BCBSA to ensure association standards are maintained.

CA audits within each processing unit are performed by quality assurance trainers, auditors, or the equivalent. The number of trainers/auditors depends on the unit size; it is their function to train and audit examiner staff. There is no set payment limit automatically requiring review; however, member payments are subject to pre-payment review. All claims paid outside the system through manual exception processing are subject to authorization levels of the staff requesting payments.

Performance Measurements

HMSA measures statistical performance through their stratified MTM audits. They follow BCBSA goals for 99% Financial and 97% Payment Accuracy. EUTF claim performance guarantees are:

- 99% of dollars paid accurately (graduated penalties from 98% to less than 97%)
- 99% of non-investigative claims processed within 30 calendar days

The accuracy goal for examiner performance in CA audits is 98%. The calculation is a combination of procedural and dollar accuracy based on whether the examiner followed established procedures and accurately paid the claim. As appropriate, results are used to identify errors for correction, address retraining needs, and increase auditing percentages.

Self-reported achievement for claims processing timeliness is based on system reports for EUTF claims that calculate the time from the date received to the date processed. Claims that require additional information or investigation are excluded from HMSA's analysis.

Segal recommends EUTF consider increasing the turnaround standard to 95% within 14 calendar days and 100% within 30 calendar days to align with industry standards. EUTF should also consider initiating a 97% Payment Accuracy performance standard, with graduated monetary penalty for non-compliance, to further enhance claim control measures.

ENROLLMENT AND ELIGIBILITY

Data Receipt/Updates

HMSA receives electronic eligibility files from EUTF twice a month; interim requests or changes are faxed daily. Within five days of receiving the electronic data, HMSA generates change reports of records for update; terminations receive priority. All changes are manually entered into the claims system with two levels of peer review. The reconciliation is validated through a second comparison of the EUTF file. If necessary, an enrollment representative will contact EUTF personnel for clarification and resolution of identified discrepancies. All updates are completed and validated within 14 calendar days from data receipt.

Retroactive Terminations

Retroactive termination dates are accepted from EUTF; however, under HMSA's internal policy for fully-insured groups, they do not pursue benefit overpayments caused by EUTF's late notification. This policy has some validity when an insurer assumes the financial risk; however, this arrangement should be reconsidered when EUTF assumes self-funding status in July 2007. Segal recommends EUTF and HMSA discuss a look-back period and dollar threshold to realize recovery where possible without undue impact on HMSA's administrative time and procedures.

COBRA Notification/Administration

EUTF retains responsibility for issuing the required notification and election letter following a COBRA qualifying event. Completed elections are returned to EUTF and forwarded to HMSA for those who elect to continue coverage under this Plan. HMSA then assumes responsibility for monthly billings and premium collection. Payments are due the first of each month; claims for services after the current pay-to-date suspend until the payment is received or coverage is terminated. Outstanding payments exceeding 30 days are subject to HMSA's automated delinquency and cancellation process. EUTF retains authority to extend the grace period or accept late payments.

CLAIMS HANDLING SYSTEM

HMSA receives approximately 83% of their total claims volume electronically, hardcopy submissions account for the remaining 17%. Hardcopy claims are sorted, batched, logged, and sent for scanning by optical character recognition (OCR) or imaging. The scanned claims are then sent for data entry; OCR data is validated while imaged claims require manual data entry. The system transfer of electronic submissions is managed by HMSA's system support staff.

Hardcopy claims are retained until they have been manually entered; scanned claims until they are processed. Paper claims that could not be scanned were microfilmed until 2003 when HMSA implemented their imaging process. All microfilmed records will be maintained until there are no further pending legal actions.

Once the claims have been entered into HMSA's system, the handling process is identical for electronic and hardcopy claims. The system auto-adjudicates 90% of all claims without

suspending for review or manual intervention. Claims that are suspended for review are downloaded into an Access database, which manages the distribution of claims for processing. Adjudication assignments are based primarily on similar services or provider specialties; some are assigned based on the type of edit (*e.g.*, COB or TPL are directed to a specialized unit).

Claims are tracked through each step of the receipt and distribution process; control totals must balance for each electronic or scanned batch. Each function (*i.e.*, mailroom, data entry, etc.) related to claims backlog is subject to established days-on-hand goals to maintain HMSA's overall turnaround time standard or performance guarantee.

PROCESSING GUIDELINES

HMSA accepts claims as billed; however, submissions with incomplete information or invalid codes are returned to the provider for correction. Signature on a form is kept on file and the system is updated to flag claims for a member or provider who have third party payees.

Reference Material

Reference material for processing guidelines is available in hardcopy and online versions. System edits may prompt decision trees to assist examiners in determining appropriate action (*i.e.*, process, refer for review, etc.) Processing guidelines are updated as needed for changes or additions. Some materials are updated annually from external sources. Staff is alerted to updates through email notification or meetings to distribute printed materials.

Coordination of Benefits

HMSA states COB documentation is obtained from claim submissions. If the claim information is not consistent with the information in the membership database, the claim will suspend for investigation. COB examiners in HMSA's Other Party Liability unit contact the other carrier if information is available, or send a COB questionnaire to the member. Claims received during a COB investigation are suspended until information is received to determine the order of benefit payment. Upon receipt of information, the system is updated to ensure correct COB on future claims; suspended claims are processed for payment. Segal recommends EUTF establish annual requests for COB information on a 12-month rolling basis with mandatory employee response requirements to ensure industry best practice is followed once self-insured.

The investigation of Medicare COB is assisted through HMSA's participation in the Voluntary Exchange of Medicare Secondary Payor Data (VDEA). This program, operated by the Center for Medicare and Medicaid Services (CMS), provides for quarterly exchange of COB information to ensure accurate determination of Medicare's primary or secondary payor status.

Workers' Compensation and Third Party Liability

In compliance with Hawaii State Statues, HMSA pays all TPL claims relating to the injury or illness for 30 days from the date of notification. All claims identified as potential workers' compensation or motor vehicle accident are reviewed by HMSA's TPL unit. Other potential TPL claims with reimbursement amounts of $500.00 or greater are also investigated through

backend reporting based on system diagnosis edits. The member is responsible for cooperating with HMSA and must provide information reasonably related to the investigation. After 30 days, HMSA denies related claims as the responsibility of another party.

Our audit included a review of TPL summary records to verify HMSA's processes; five samples were randomly selected from a list of EUTF cases within the audit period. HMSA indicates TPL cases are assigned a case number, logged, and monitored for required follow-up and correspondence through settlement or other closure. Our review confirmed each sample was tracked with a case number, diagnosis, initial determination to investigate, and progress notes. Current status for the five cases falls under one of the following categories: open for attorney information, recovery in process due to no response, TPL questionnaire to member (two cases), and confirmation of homeowner's liability. Dates and action support timely and appropriate follow through.

Blue Card Claims/Out-of-Pocket Calculation

When an HMSA covered member incurs charges through an out-of-state BlueCross or BlueShield provider, benefits are considered in-network under BCBSA's Blue Card program. The out-of-state BlueCross BlueShield carrier (host plan) applies their contract allowance for services; the claim is then electronically transferred to HMSA for plan benefit determination. HMSA adjudicates the claim to calculate Plan benefits, including coinsurance up to the calendar year out-of-pocket maximum; however, HMSA does not finalize the claim until the host plan returns their provider payment information.

Errors were assessed on Worksheets 174, 183, and 186 for excess coinsurance application due to other claims HMSA processed between their original Blue Card benefit calculation date and the date the claim was finalized by the host plan payment. HMSA does not currently track these claims for corrective action. Segal recommends HMSA implement procedures to update the member's calendar year out-of-pocket when a Blue Card claim is originally processed for benefit calculation to prevent excess member liability. Should the host plan payment change upon finalization, HMSA would correct their claim and out-of-pocket, as appropriate.

Interim Hospital Billings

HMSA currently denies interim inpatient hospital billings; reimbursement is made upon patient release based on the final billing of total charges incurred. In response to Segal's inquiry regarding payment calculation on Worksheet 210, HMSA's internal auditors reviewed all related interim billings and identified provider billing errors that resulted in an $83,135.25 overpayment. HMSA states they will implement an additional audit function to review all submissions for a confinement with interim bills.

Our audit sample included four long term inpatient confinements resulting in multiple interim billings. Segal recommends HMSA and EUTF discuss procedures that will facilitate advance and ongoing notification of pending large dollar hospital claims to ensure management reports and advance funding considerations are addressed under the Fund's upcoming self-funding arrangement.

COMMUNICATIONS TO PROVIDERS AND PARTICIPANTS

Requests for Claim Information

Requests for additional information may be initiated through a message on the claim explanation of benefits (EOB) or through use of form letters, as appropriate. Members are notified when additional information is requested from the provider; the provider's request details the information necessary to complete claim adjudication. Pended claims are closed after 45 days if no response is received; a new claim will be considered if the requested information is submitted at a later date.

Appeal Process

HMSA's EOB includes information for filing a written appeal of an unfavorable determination within one year of the decision date. Members are sent formal appeal forms within one working day of verbal requests. Appeals are monitored by the designated coordinator through assigned case numbers. A daily report indicates the due date of each appeal; a three-month calendar tracks all open cases.

An administrative review panel, consisting of HMSA supervisory personnel, reviews member appeals for decisions involving non-clinical issues (*i.e.*, eligibility, benefits, etc.). An appeals committee comprised of HMSA Board physicians, lay members, and appointed practicing physicians reviews member appeals that involve clinical issues. If an appellant disagrees with HMSA's appeal decision, the EUTF Guide to Benefits outlines the member's request for arbitration and/or review by the Hawaii State Insurance Commission rights.

Provider appeals are reviewed by a medical director or consultant not involved in the original determination process. If a fully favorable decision is not achieved, the appeal is forwarded to HMSA's Administrative Review Panel or the HMSA Appeals Committee. Additional information will be requested throughout the review process, as appropriate.

A procedural error was assessed on Worksheet 161 for untimely review of a provider appeal. The provider did not send the appeal to the designated address; it was directed to a provider relation representative with HMSA. Although the appeal was delayed due to the representative's prolonged absence, the claim was subsequently reconsidered following review.

Segal's scope of audit services included a review of sample appeals to verify HMSA's process for follow-up and timeliness (*e.g.*, whether the appeal was urgent, pre-service, or post-service). Five samples were selected from an appeal report provided by HMSA for our review. Segal verified case documentation identifying the source of the appeal receipt (member or provider), follow-up dates, and assignment of review by an appropriate provider specialty. All sample appeals were accurately logged based on supporting correspondence dates; follow-up activity and status were noted. Four appeals were closed; one provider appeal remains open with a request to the provider for additional supporting documentation.

PROVIDER FILES AND MAINTENANCE OF FEE SCHEDULES

Provider Maintenance

Provider records are restricted to specialized HMSA provider representatives. All changes, including new and terminated contract records, are subject to two levels of peer review as forms are completed for system updates. Before the information is data entered, the coding sheet is also reviewed to determine whether the information from the source document is completely and accurately reflected. The coding sheet is then used to verify the system data entry.

Other provider functions are performed by HMSA staff responsible for direct provider relations or printed and web-based communications. Providers are advised of changes in HMSA's procedures that may affect billing practices or approval procedures. HMSA issues eight provider newsletters annually; they are required to provide 60-day notice of any fee schedule changes.

Network Fee Schedules

Allowances vary by type of service; Diagnostic Related Groups (DRG), per diem, and scheduled fee for service typically apply. An automated system process classifies DRG claims using the Medicare grouper; Segal verified this process through our individual claims review and system testing. DRG allowances may result in a negative savings (allowance greater than billed charge); however, the member's coinsurance is based on the lesser of the DRG allowance or the covered charges.

Fee changes may be performed annually or per provider contract terms via data entry by HMSA provider services staff or file upload. Facility and physician pricing is an automated process based on fees maintained in the claims system; facility claims exceeding the contract "outlier" threshold may require manual calculation. Segal's auditor requested and reviewed a copy of the contract terms for one facility claim within our audit sample; accuracy of the manual calculation process was confirmed.

Out-of Network Fee Schedules

HMSA uses an internally developed Maximum Allowable Charge (MAC) schedule for reimbursement of services from out-of-network providers. The MAC fees reflect a level of relativity to Medicare fees, but their weight is determined based on an overall budget. MAC fees are reviewed annually based on the past two year history of all submitted cases and providers for various service types or specialties; provider feedback is also considered. The review provides for opportunity to align any groups of services with Medicare where appropriate, subject to the total budget. MAC fees are updated annually on January 1st; prior fees are maintained electronically for retrieval based on date of service.

CLAIM CONTROL MEASURES

Our administrative review and audit sample revealed HMSA utilizes the following claim control measures in the processing and payment of claims:

- HMSA receives 83% of claims via electronic submission; the system auto-adjudicates 90% of all claims without suspending for manual intervention.

- System edits are in place to recognize provider unbundling or upcoding. As part of their fraud detection process, claims with suspected altered or added charges receive post-payment review by HMSA's Benefits Integrity Department.

- Pre-certifications for required outpatient procedures are electronically transferred nightly to the claims system for automatic association with corresponding claim submissions.

- HMSA provides case management for complex medical conditions, those requiring extraordinary care, or complex discharge planning such as:

  - neonate or fragile child
  - primary medical with complex psycho-social situation
  - life-limiting or advanced chronic disease
  - end-of-life care/terminal illness
  - medical condition complicated by drug or alcohol dependency

  Case management was confirmed through a review of case documentation for a transplant claim.

- Hospital bill audits and utilization review are performed post-payment and identified by specified criteria based on diagnosis, procedure, length of stay, etc. Payments may be recovered from the provider for unnecessary or unconfirmed services identified through the record or billing review; the patient is not penalized.

  HMSA provided a report of 20 hospital audits for EUTF claims during the audit period. This number appears reasonable as most hospital claims are calculated on a DRG basis and may be reviewed under HMSA's DRG audit program.

- A formal wellness/disease management program is provided for every member identified with one of the designated chronic conditions, whereby members receive interventions (health guide, reminders, and educational materials) promoting an understanding for managing their chronic condition; other members receive reminders for overdue preventative care. A member must notify the Plan if they elect to "opt-out" of the program. This information was provided by HMSA through response to Segal's administrative questionnaire.

FINANCIAL ACCOUNTING

Premium Payments and Reconciliation

HMSA reports they receive EUTF contributions by a physical check, which is picked up at EUTF's office for bank deposit. COBRA premium payments are received directly by HMSA through their normal billing and payment process. A rate calculation based on EUTF enrollment files for non-COBRA revenue is performed monthly. Quarterly reports are provided to EUTF via mail and electronic copy.

Overpayment Recovery

HMSA employs various thresholds for overpayment recovery procedures. Claims related to TPL, no-fault automobile, and workers' compensation are subject to investigation when reimbursable amounts exceed $500.00. Suspected fraud and claims resulting in duplicate payments are pursued at management's direction. Overpayments in excess of $100.00 to network providers are recovered 30 days after notice of intent to deduct. All other requests are sent to the payee with a copy to the member; follow-up requests are set for 30, 60, and 90 days.

System accounting software is used to track overpayment requests; each situation is unique and fully documented for management reports. HMSA reports a 97% recovery rate. If a member or out-of-network provider refuses to honor a refund request, the claim is elevated for management review. HMSA retains the option to consider filing suit or referring the case for collection. HMSA and EUTF should discuss any procedure changes that may become necessary once the group is self-insured. Segal recommends HMSA and EUTF extend their $100.00 threshold to suspected fraud and duplicate payments; reduction through current benefits payable should be considered for refusal or non-response to refund requests.

CLAIMS PROCESSING SYSTEM

EUTF claims are processed on the Long Range System Planning (LRSP) system developed by a group of BlueCross BlueShield plans. The system has the ability to identify unbundled codes, incidental or incompatible procedures, upcoding, etc. without the use of external editing software. These system edits, including duplicate claim identification, were confirmed through our individual claims review and system testing. In discussion, HMSA advised Segal auditors that a new claim processing system has been installed with migration of select groups initiated; plans are in place for transition of EUTF claims processing by the end of 2007. Segal recommends HMSA provide EUTF with updates as the project progresses. EUTF should consider a system parameters review to confirm benefit design accuracy on the new system prior to or immediately following live claims processing.

System Security

Changes to plan design, enrollment records, accumulators, MAC schedules, provider records, and cost containment records are restricted by various staff and department levels. Direct access to data in production is restricted to database administrators. System developers and administrators do not have access to production business data. Developers must route changes

through quality assurance and production control for the transaction to be executed in the live environment.

Individuals attempting unauthorized access are identified on system generated reports that are shared with the assigned supervisor. All security violations are monitored and reports are generated. Sharing of individual passwords may result in disciplinary action up to and including termination. This policy extends to shared use of individual badges for physical security.

Segal selected five potential security violations from reports provided by HMSA for our review. The security officer facilitated system access for the auditor to observe reporting procedures and verify incidents were investigated with corrective action, as appropriate. Based on our onsite observations, all established procedures were confirmed.

Although not directly related to their claims processing system, HMSA uses an encrypted email program to secure incoming and outgoing transmissions. All laptop computers provided for remote use are encrypted to minimize accidental access to protected or proprietary information.

Power Failure/Disaster Recovery

In the event of a full power failure, all critical systems in the primary HMSA data center are supported by uninterrupted power sources to minimize the loss of data. No historical data would be lost as full system and data backups are performed nightly; at most, the current day's work would be lost.

In the event of a disaster, HMSA executes their emergency response plan immediately. A key step in HMSA's emergency response plan is an assessment of the situation at the time by senior management to ensure as timely a recovery as possible. Key roles have been identified with both primary and secondary contact individuals assigned. Time to recover is primarily dependent on the nature of a particular disaster (*i.e.*, fire, hurricane, flood, etc.). Various plans are validated through desktop review or live system test, typically on an annual basis.

SUMMARY OBSERVATIONS

Segal's observations on the following topics are offered to assist EUTF in considering procedures that may require review or change as EUTF transitions to a self-funding arrangement for Plan benefits.

- *Vendor Outsourcing* - Pacific Collections retains 33.33% of overpayment recoveries; the fee increases to 50% for out-of-state providers or cases requiring litigation. Percent of recovery rate is greater than we normally observe. Segal recommends EUTF confirm any changes to vendor fees under their self-funding arrangement.

- *Call Center Operations* - After-hour messaging services is common within the industry to provide extended call-in service. Segal recommends HMSA investigate a system enhancement that would facilitate after-hour messages.

- *Performance Measurements/Guarantees* - EUTF should consider 1) increasing the turnaround standard from 99% in 30 calendar days to 95% within 14 calendar days with 100% in 30 calendar days; 2) initiating a 97% Payment Accuracy performance standard, with monetary penalty, to align with industry standards.

- *Retroactive Terminations* - Segal recommends EUTF and HMSA discuss a look-back period and dollar threshold to initiate recovery where possible without undue impact on HMSA's administrative time and procedures.

- *Coordination of Benefits* - To follow industry best practice, Segal recommends EUTF establish annual requests for COB information on a 12-month rolling basis with mandatory employee response requirements.

- *Network Fee Schedules* - Segal recommends HMSA and EUTF discuss procedures to facilitate advance and ongoing notification of pending large dollar hospital claims as interim billings are received; this will ensure management reports and advance funding considerations are addressed.

- *Overpayment Recovery* - HMSA and EUTF should discuss a dollar threshold for all types of overpayment recovery with reduction of current benefits payable in case of refusal or non-response to refund requests.

- *Claims Processing System* - EUTF should consider a system parameters review to confirm benefit design accuracy on HMSA's new system prior to or immediately following live claims processing.

A total of 1,621,316 EUTF claims, representing $227,222,383.52 in benefit payments, were paid during the period July 1, 2005 through June 30, 2006. Our statistical audit sample of 210 claims reviewed $4,763,615.24 in benefits paid on behalf of eligible employees and their dependents.

A target selection of 15 zero payments was reviewed to ensure claims were processed appropriately for deductible application and denial; 371,960 zero payment claims represented 18.66% of all claims processed. Due to sample size requirements, these claims are treated as a target sample and not included in our stratified sample or factored into the calculation of statistical achievement.

An integral part of our analysis includes a review of individual claim payments to ensure accuracy in benefit determinations and compliance with established administrative procedures. Our stratified sampling process allows us to project the accuracy of all claims based on the results of our audit selection. A detailed breakdown of the strata used in this analysis can be found in Exhibit C at the end of this section.

For purposes of our audit, a claim is defined as "all charges submitted and processed for payment under one claim number, including subsequent adjustments." Prior history and accumulators (deductibles, coinsurance, and benefit maximums) were reviewed, as applicable. In addition to verifying the amount paid, claims audited were thoroughly reviewed to determine that:

- Claims were paid in strict accordance with Plan provisions.
- Amounts paid were within the designated network schedules and/or Maximum Allowable Charges (MAC) allowances for the area where treatment was rendered, with due consideration given for the severity of the condition treated. We did not determine medical necessity, but did ascertain HMSA reviewed or referred claims for such review as appropriate.
- Claims were paid only on behalf of eligible individuals, based on eligibility provided by EUTF.
- Documentation (provider bills, physician statements, surgical reports, etc.) was on file for claims paid and was verified when necessary.
- Benefits were paid under the proper benefit classification, diagnostic, and procedure codes.
- Appropriate benefit limitations, deductibles, coinsurance, and out-of-pocket maximums were applied.
- Arithmetic calculations were correct.
- Coordination of benefits with other coverage and third party liability provisions were enforced, where applicable.
- Duplicate payments were properly denied.

- Payments were made to the proper party (*i.e.,* the provider of service if benefits were assigned; the employee if benefits were not assigned).
- Turnaround time for processing claims was within performance guarantees.

SELECTION OF CLAIMS

The selection of claims was stratified by dollar amount to give large claims more valid representation in the sample. The methodology of our stratified selection process utilizes formulae designed to take full advantage of statistical sampling procedures that allow a quantifiable degree of confidence so the results obtained in the audit sample are a true reflection of the actual way all claims were processed during the audit period.

DETERMINATION OF ERRORS

For comparison to industry standards, processing errors have been classified as "payment" or "procedural." Procedural errors do not involve a variance in payment. Claims containing multiple errors were counted as one error in determining accuracy levels achieved in this report. "Other claim matters" are noted for corrective action on non-sampled claims; these are excluded from our statistical analysis of achievement.

STRATIFIED SAMPLE PROCESSING ACCURACY

Of the 210 stratified claims audited, 203 were processed without error. Five payment errors totaled $1,014.47; two procedural errors were assessed. Separate Financial Accuracy results for one overpayment ($240.00) and four underpayments ($774.47) reflect 100.00% (rounded at two decimals after the point) and 99.94% respectively. Other claim matters identified during the review of related patient claims histories revealed three potential or confirmed file payment errors totaling $83,546.02 (two overpayments for $83,417.86; one underpayment of $128.16).

A basic principle of the sampling technique is that the audit findings are representative of all claims; therefore, the respective strata error rate is used to project the total errors for each stratum. The total projected errors are used to calculate the statistical accuracy levels for comparison to industry standards. Based on the statistical findings reflected in the following chart, HMSA met performance standards for the accuracy of benefits and processing timeliness. Industry standards are included for comparison.

Performance Measurements				
Category	**Sample Results**	**Stratified Achievement**	**Performance Guarantees**	**Industry Standards**
Financial Accuracy (dollar value)	99.98%	99.94%	99%	99%
Processing Accuracy (without payment or procedural error)	96.67%	99.77%	N/A	95%
Payment Accuracy (free from financial error)	97.62%	99.95%	N/A	97%
Turnaround Time (within 30 calendar days)	100%	100%	99%	100%

SUMMARY OF ERRORS

The following table categorizes the payment errors, procedural errors, and other claim matters identified during this audit period. All errors are identified; however, only one error per claim was used in the statistical accuracy calculation.

Type of Error	Payment	Procedural	Other Claim Matters
Benefit Calculation			
Manual out-of-pocket adjustments	2	-	1
Blue Card out-of-pocket processing	2	-	-
Non-covered expenses	1	-	1
Claims Handling			
Delayed Appeal	-	1	-
Documentation			
Other insurance coverage	-	1	1
Totals	5	2	3

A detailed listing of errors identified by audit worksheet number is included as Exhibit A. All questions and comments regarding the statistical and target claims samples were reviewed with HMSA. We recommend the underpayments be reopened and additional payment sent to the member and/or provider with an explanation. Recoveries should be initiated for overpayments based on HMSA's $100.00 minimum recovery threshold.

TURNAROUND TIME – STRATIFIED SAMPLE

Turnaround time was calculated from the date a claim was received to the date it was processed by payment or denial. Claims which required additional information were calculated using the

longest interval between the received date as documented on the claim and date the claim was pended, or the date a response was received and date the claim was processed by payment or denial. This analysis included routine delays due to internal review or provider maintenance; delays realized for draft issuance were excluded from our analysis.

As noted in our analysis of accuracy levels, the process of stratification requires an adjustment in our audit observations. This is also true for the analysis of turnaround time. Accordingly, our analysis weights claims by strata, giving due consideration to the processing complexity for claims that are similarly grouped (*e.g.*, small dollar claims require less time to process than large dollar claims subject to internal reviews).

HMSA's performance guarantee is to process 99.0% of Non-Investigative Claims within 30 calendar days. Claims pended for investigation and/or additional information are excluded from their analysis. Segal's review included claims that required multiple processing events (*i.e.*, pended or adjusted transactions), reporting the single longest time interval from received to processed dates.

Two claims were excluded from our analysis as they were received prior to the audit period. Based on the extrapolated analysis of 208 sampled claims, 99.66% of all claims were processed within eight calendar days. This exceeds both HMSA's performance guarantee and industry standards. A detailed analysis of the turnaround time observed on the stratified claims selection is included as Exhibit B at the end of this section.

ZERO PAYMENT TARGET SELECTION

A target selection of 15 zero payments was reviewed to ensure claims were processed appropriately for deductible application and denial; each was correctly adjudicated. Prior history and accumulators (deductible and coinsurance) were reviewed on each sampled claim, as applicable.

Typically, any identified errors on these claims are factored into the statistical calculation of overall and coding accuracy; however, it was determined that the population of zero payment claims required a larger number to be selected for statistical validity. To remain within the scope of the proposed audit relative to the number of claims to be reviewed, these were handled as a separate target selection.

TARGET PRESCRIPTION CLAIMS SELECTION

Our prescription plan analysis included two processes: an electronic analysis of all claims performed in advance of our onsite audit, and a review of 25 potential exception claims (identified through our electronic analysis) for individual review. Our target sample was comprised of the following discrepancy types:

- Prior authorization required
- Sexual dysfunction - all excluded
- Injectables - excluded

- Retail brand products with generic copay ($5.00 or less)
- Retail non-formulary products - less than $30.00 copay
- Mail brand products with generic copay ($10.00 or less)
- Mail non-formulary products - less than $60.00 copay

Documentation for each sample was reviewed with HMSA during our onsite audit; the following explanations validated 24 samples were correctly administered.

- Copay discrepancies were due to:
  - secondary payor balance (paid primary plan copayment only)
  - criteria for analyzing brand products for formulary or non-formulary status
- Ineligible expenses were appropriately denied (*e.g.*, the system calculates benefits for all claims; however, the status code indicates payment was denied)

One overpayment of $2,897.11 was identified for benefits paid without authorization as required for the prescription product. HMSA performed an electronic query for this product, identifying 53 claims; two were processed without authorization. HMSA states they will research the source of this problem for correction.

Based on further discussions with HMSA representatives, and auditors' observations from our sample review, the original prescription drug queries were refined for further electronic analysis. Results of the electronic prescription drug review will be provided to EUTF under separate report cover.

EXHIBIT A – ERROR LISTING

Worksheet	Over/(Under) Payment	Explanation
154 F	Procedural	**$947.73 potential overpayment.** Newborn's other parent was enrolled under another HMSA plan; the other coverage may be primary due to birthday rule order of determination. **$282.61 possible file overpayment.** Other newborn charges may be eligible for primary coverage under the plan of the parent with earliest birth date.
161 G	Procedural	Untimely handling of an appeal resulted in second denial of charges. *HMSA advised that the provider misdirected the appeal to an HMSA network representative, contributing to the delay.* The claim was subsequently reconsidered for payment.
173 H	($227.02)	Calendar year out-of-pocket was exceeded due to manual claim adjustment.
174 H	($8.45)	Calendar year out-of-pocket was exceeded due to standard processing procedures for Blue Card claims.*
183 I	Other Claim Matter	**$128.16 file underpayment.** Calendar year out-of-pocket maximum was exceeded due to standard processing procedures for Blue Card claims.*
186 I	($412.75)	Calendar year out-of-pocket was exceeded due to standard processing procedures for Blue Card claims.*
208 K	($126.25)	Calendar year out-of-pocket was exceeded due to manual claim adjustment.
210 K	$240.00	Examiner analysis of a ten-month hospital bill failed to properly calculate non-covered expenses. **$83,135.25 final overpayment.** Subsequent review by HMSA internal auditors identified multiple provider billing errors for recovery.
Totals	$1,014.47	4 Underpayments ($774.47) 1 Overpayment ($240.00) 2 Procedural Errors 3 Other Claim Matters ($83,546.02)

* HMSA adjudicates Blue Card (out-of-state BlueCross or BlueShield) claims to calculate Plan benefits for the "host" state's payment; however, HMSA does not finalize a claim to update the out-of-pocket maximum until the host plan returns their provider payment information.

EXHIBIT B – TURNAROUND TIME – SAMPLE ANALYSIS

Calendar Days	Number of Claims	Individual Percent	Cumulative Percent*
0	111	63.77%	63.77%
1	47	19.48%	83.25%
2	14	7.05%	90.31%
3	6	3.36%	93.66%
4	7	2.10%	95.77%
5	1	0.77%	96.54%
6	4	1.71%	98.25%
7	2	0.49%	98.74%
8	2	0.92%	99.66%
9	0	0.00%	99.66%
10	3	0.08%	99.74%
13	1	0.00%	99.74%
15	1	0.00%	99.74%
16	2	0.07%	99.81%
17	2	0.04%	99.85%
18	1	0.00%	99.85%
19	1	0.13%	99.97%
21	1	0.00%	99.97%
22	2	0.03%	100.00%
Total	208	100.00%	*may not add due to rounding

EXHIBIT C – STRATIFICATION TABLE

Strata	Dollar Range of Strata	Number in Audit Selection	Number of Claims in Range	Dollar Amount in Audit Selection	Total Dollar Amount in Strata
A	$0.01 - $29.99	45	577,222	$655.35	$8,066,198.13
B	$30.00 - $59.99	40	488,047	$1,910.53	$23,903,832.80
C	$60.00 - $119.99	25	314,051	$2,148.72	$27,196,016.91
D	$120.00 - $269.99	20	136,843	$3,681.71	$23,289,799.68
E	$270.00 - $624.99	15	59,953	$6,059.45	$24,292,878.99
F	$625.00 - $1,549.99	15	30,438	$14,830.32	$29,392,788.22
G	$1,550.00 - $4,199.99	10	9,649	$27,670.32	$23,403,346.78
H	$4,200.00 - $9,999.99	10	3,196	$63,646.00	$20,183,086.05
I	$10,000.00 - $24,999.99	10	1,413	$142,574.28	$21,791,264.44
J	$25,000.00 -$159,999.99	10	494	$401,797.06	$21,604,530.02
K	$160,000.00- $474,157.71	10	10	$4,098,641.50	$4,098,641.50
Totals		210	1,621,316	$4,763,615.24	$227,222,383.52

The electronic data revealed 301,960 zero payments, representing 18.66% of the total claim population during the audit period. Zero payments claims did not result in a financial reimbursement; they represented denials for duplicate claims, timely filing, non-response to additional information request, non-covered expense, and claim history adjustments.

Eligibility records were reviewed for each sampled claim that was audited; all records confirmed active coverage for the corresponding dates of service. The scope of our audit services also included the following eligibility reviews; our processes incorporated electronic analysis and individual transaction review.

- EUTF and HMSA eligibility records comparison
- HMSA eligibility records vs. claim payments
- Overage dependents (full-time students aged 19 to 24; disabled children over age 18)
- 15 target EUTF eligibility transactions selected by EUTF

EUTF AND HMSA RECORD COMPARISON

This electronic analysis was performed through a full-file comparison of eligibility data provided for our review by HMSA and EUTF. Identified file discrepancies were divided into two primary categories: 1) HMSA records with no corresponding EUTF record, and 2) records with different eligibility dates. Segal auditors reviewed sample findings with HMSA during our onsite audit; HMSA system and eligibility documentation for sample discrepancies revealed:

- HMSA data included records for members who terminated with EUTF prior to the eligibility date range provided by EUTF
- HMSA maintains COBRA enrolled dependents under their individual social security number (not linked to the original member's identification or social security number)
- HMSA data included eligibility dates for EUTF subscribers who may also have periods of coverage under another HMSA administered plan (*e.g.*, EUTF and non-EUTF eligibility was provided)

These findings are based on our review of a limited sample of discrepancies identified through our electronic analysis. The scope of our review does not cover a complete eligibility reconciliation; however, it does offer a level of confidence in the overall record accuracy. Segal will provide the complete list of file discrepancies under separate cover, upon request, should EUTF decide to perform an in-depth reconciliation.

HMSA ELIGIBILITY AND CLAIMS COMPARISON

Segal performed an electronic comparison of eligibility and claim payment files provided by HMSA for our sample selection and review purposes. Our analysis revealed potential ineligible claims for 1) dependents with no coverage, and 2) services outside the member or dependent eligibility dates. HMSA was provided with our preliminary report of findings for research and response.

Segal auditors reviewed our query findings and HMSA's responses during our onsite visit. The number of dependents with no coverage and participants with services prior to their effective

date was relatively small, allowing verification of each corresponding system eligibility record. All potential discrepancies were eliminated following review of multiple data records reflecting eligibility status changes (*i.e.*, active, retiree, address updates, etc.).

The list of benefits paid after termination of coverage was extensive; Segal auditors reviewed HMSA's sampled findings. HMSA confirmed the payments on the records they researched were the result of retroactive termination notices from EUTF. Our analysis identified benefit payments totaling $391,024.18 for services after the patient's termination date. This finding is offered for informational purposes; HMSA agrees to accept retroactive terminations but they do not pursue overpayment recovery. Segal highly recommends reconsideration of the policy when the Fund moves to a self-insured arrangement.

OVERAGE DEPENDENTS

EUTF determines qualifying status of dependent children as part of their eligibility responsibilities; HMSA processes claims for all dependents reported as eligible, regardless of age or relationship code (*e.g.*, child, student, or handicapped). Segal performed electronic analyses to identify the number of eligible dependents and benefit payments at ages 19 through 23 and age 24 or older with corresponding relationships to assist EUTF in identifying potential areas of concern. Our original analyses were based on a comparison of birth dates and service dates; we refined those query results by:

- Comparing birth dates with terminations on the 1st or 16th of the following month that eliminated dependents at the qualifying ages of 19 or 24.
- Eliminating benefit payments previously included in the total paid for retroactive terminations identified in our HMSA Eligibility and Claims Comparison.

The results of our analysis revealed 269 dependents, ages 19 through 23, who were identified as children with eligibility for some months during the audit period. A list of these dependents will be provided upon request should EUTF decide to perform a follow-up review by individual. The table below summarizes our findings separately by active enrollment and benefit payments; not all covered dependents received benefits during the audit period.

Number of Dependents			
Dependent Age	**Relationship Status**		
	Child	**Student**	**Handicapped**
19 through 23 years	269	6,971	50
24 years or older	-	379	287
Totals	269	7,350	337
Amount of Benefit Payments			
19 through 23 years	$33,891.61	$2,761,964.68	$58,255.55
24 years or older	-	$688.17	$362,220.58
Totals	$33,891.61	$2,762,652.85	$420,476.13

TARGET ELIGIBILITY TRANSACTION

To review accuracy of HMSA's records, timeliness of updates, and compliance with COBRA requirements, EUTF provided Segal with a list of 15 transactions.

- Five indicating termination of coverage
- Five with a status change
- Five COBRA applications

HMSA provided documentation of transaction requests and system updates; monthly payment records for COBRA enrollees confirmed the accuracy of continued coverage. Our review revealed discrepancies on the following two records; each was explained through additional discussion and research.

- Termination of Coverage: HMSA was unable to identify a member for one sample transaction. A EUTF representative advised Segal that the sample was provided in error; the member is covered under the Kaiser HMO plan option.
- COBRA Election: HMSA did not have record of receiving an election for one sample transaction. Through follow-up conversation with a EUTF eligibility staff member, HMSA was advised that the election form was not sent to HMSA. The member response did not include election for continuation of HMSA plan coverage; a copy of the election form faxed by the EUTF contact was provided as documentation.

Segal's scope of services included electronic analyses for potential duplicate payments, use of standard procedure codes, and claims processing turnaround time. Each analysis involved an initial query prior to our onsite visit; sample findings were presented to HMSA for their review and validation of our query process. Findings were further addressed as part of the onsite process. The procedure code and turnaround time analyses were performed on claims processed from July 1, 2005 through June 30, 2006; the potential duplicate analysis included an expanded period from January 1, 2005 through June 30, 2006.

POTENTIAL DUPLICATE PAYMENTS

Our review of sampled claims found no duplicate payments. An electronic query of all claims processed January 1, 2005 through June 30, 2006 was conducted to identify potential duplicate payments. The process began with identification of claims containing an exact match on billed amount, employee number, claimant, provider, service date, and procedure code (including modifier). Due to limited data fields, claims with mental health and HIV diagnoses were excluded from our analysis.

Our original query findings identified potential duplicate charges representing approximately 4.30% of total benefits paid during the audit period. Our list was not expected to identify data entry errors (*i.e.,* incorrect patient, date of service, provider). HMSA performed a validation process of potential duplicates over $200.00, researching claim documentation for explanation or confirmation.

Segal auditors reviewed HMSA's results, modified our query, and verified our revised findings via HMSA's original research and online claims documentation. The primary explanations for eliminating potential duplicates were:

- Adjustment transactions (originally processed prior to or during the audit period)
- Multiple services (ambulance trips, emergency room visits, pathology samples)
- Twin dependents
- Late or additional provider charges

The majority of confirmed duplicate transactions occurred on manually processed claims; this is consistent with expectations for human intervention. Segal also noted a recurrence of identified duplicates on Blue Card (interstate provider) claims. These claims are manually adjudicated through a separate process with the "host state" Blue Cross plan and not subject to the same electronic edits applied to in-state claims. HMSA states they constantly strive to improve Blue Card procedures to reduce incidents of duplicate benefit payments.

A revised list of potential duplicates, based on HMSA and Segal review, was presented to HMSA at the conclusion of our onsite visit. We recommend HMSA advise EUTF of the amount of confirmed duplicates and appropriate corrective action. Segal's opinion, based on our limited findings, is that the value of potential duplicate payments does not warrant further audit time or expense.

STANDARD PROCEDURE CODES

The use of universally accepted codes for billing and processing claims becomes more critical with increased electronic submissions and auto-adjudication levels. To ensure HMSA uses industry standard procedure codes vs. "home-grown" or internally developed codes, Segal performed an electronic analysis comparing HMSA's data with current industry assigned procedure codes. Results from claims processed July 1, 2005 through June 30, 2006 identified approximately 800,000 procedures with non-standard procedure codes.

HMSA explained they use approximately 180 non-standard procedure codes, which are automatically converted from industry standard format during processing. The use of non-standard codes aids in recognition of benefits that are unique to a particular plan or benefit type, special HMSA programs (*i.e.,* Healthpass), bundled procedures, contracted rates, etc.

The system uses a conversion/crosswalk table that links the standard and non-standard procedure codes. The standard code is maintained with the claims data for reporting purposes or data transfer to another entity, if required.

ELECTRONIC TURNAROUND TIME ANALYSIS

Segal performed an analysis of all claims processed within the audit period as a comparison to HMSA's self-reported achievement and performance guarantees. Our results are calculated from the received date to the date processed for each individual claim transaction; we were unable to track multiple transaction dates on a single claim (*i.e.,* pend responses or adjustments). Processing time between 100 to 400 days was evidenced on 4,909 claims; 746 exceeded 400 days. These transactions may represent overall time on adjusted claims originally processed prior to our audit period; however, definitive determination would require review of the actual claim documentation. Quarterly performance for all claims is presented in the following table.

Quarterly Performance – Calendar Days			
Processed Dates by Quarter	**Number of Claims Processed**	**Number of Claims Processed in 30 Days**	**Percent Achieved at 30 Days**
July 1, 2005 - September 30, 2005	417,892	414,831	99.27%
October 1, 2005 - December 31, 2005	426,586	423,186	99.20%
January 1, 2006 - March 31, 2006	394,586	386,340	97.91%
April 1, 2006 - June 30, 2006	382,252	373,746	97.77%

Various claims tests were performed to ensure proper measures are in place for accurate administration of plan benefits. Under the supervision of Ms. Sheldon, specific claims were entered into the system by a HMSA analyst; modified claims were then input and observed for claims processing and system edits.

Segal's review of sampled claims and input of test claims verifies the system accurately calculates, accumulates, and automatically denies services over the applicable benefit maximums with the following two exceptions:

- Systemic tracking problems for the calendar year copayment maximum, as evidenced in the claims sample, result from HMSA's internal procedures for Blue Card claim submissions and payment calculations. HMSA is aware of this issue and is researching methods to resolve the problem.
- Allergy testing services can exceed the Plan's limit of one series per year. Segal recommends HMSA define test series codes for their system to identify and deny allergy series that exceed the Plan's yearly maximum.

The results of our system tests are intended to assist EUTF in determining HMSA's automated vs. manual processes and accuracy of system plan building. The benefit testing review is not expected to encompass every claim type or opportunity for examiner oversight or manual processing error. Appropriate edits or denials were noted for tests as described below.

System Suspends – This automated function results in the claim and/or benefit in question being placed in a suspended mode during the nightly claims run. Claims editing into the suspense mode require "next day" manual review by an examiner to determine whether the claim should be reimbursed or denied. The system provides detailed denial or processing rationale for examiner use as appropriate. It is noted that the system does allow manual overrides by the examiner; however, management reports are generated to monitor edit and override activity. The following test claims automatically suspended for examiner review:

- Acupuncture
- Podiatry
- Private duty nursing
- Tempromandibular joint (TMJ)
- Gender specific diagnosis or procedure codes
- Impacted tooth
- Air ambulance

System Denials – The system is programmed to automatically deny the following:

- Benefit types based on the current procedural terminology (CPT) or diagnosis code:
  - Cardiac rehabilitation
  - Chiropractic
  - Obesity
  - Orthotics (other than related to diabetic conditions)
  - Radial keratotomy
- Claims incurred prior to and past the eligibility effective and termination dates
- Claims submitted past the 12-month filing limitation
- Benefit submissions exceeding Plan maximums:
  - Hearing aides (allowed one per ear every five years)
  - In-vitro fertilization (allowed one service per lifetime with the proper authorization)

Benefit Calculation – The system is programmed to automatically calculate the correct benefit for the following:

- Multiple surgical procedures
- Well woman
- Well child
- Bilateral surgical procedures
- Anesthesia

Benefit Tracking – The system is equipped with an automatic tracking device that reviews claims in history to accurately calculate the benefit utilized and remaining for:

- Durable medical equipment (based on rental charge up to purchase price)
- Skilled nursing facility (allows 120 days per calendar year)
- Physical therapy (frequency and duration based on physician's orders)
- Pap smear (one per calendar year)
- Mammogram (one per calendar year for females 40+ years)

Sampled Claims – The following benefit scenarios and accurate system processing (including applicable maximums) were observed on claims included in our statistical sample:

- Deductible and copayment application and accumulation
- Immunizations
- Emergency room
- Psychiatric inpatient and outpatient

- Routine examination
- Inpatient facility payments based on DRG pricing
- Well woman and well child benefit maximum

Our review of test and sampled claims confirms HMSA utilizes processing software to recognize and recode unbundled and incidental procedures. The system automatically calculates the applicable allowances based on recognized diagnostic laboratory panels.

HMSA indicates a conversion is currently underway to implement a new processing system; timing for transition of EUTF claims is under discussion. HMSA states EUTF will be notified prior to the initiation of this process.

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HMSA Internal Audit

Segal Section	Comments and Recommendation	HMSA Comment
Page 5, Comments and Recommendations	Overpayment recovery fees (33.33% or 50%) are greater than we normally observe; 17% to 30% is a more standard range. Recovery from network providers reduces the potential need for collection services; however, EUTF should confirm any changes to vendor fees under their self-funding arrangement.	We would like more detail to be provided in this comment. The overpayment recovery fees are fees charged by a third party collection agency. It is also our last resort after we have exhausted all of our internal resources (i.e. went through our internal refund request protocol, legal action), therefore it is not used frequently. Looking forward to when EUTF has a self-funded arrangement, they will have the discretion of using the collection agency, or choosing another one.
Page 5, Comments and Recommendations	HMSA should investigate a system enhancement to facilitate after-hour messages for expanded caller access.	If EUTF wants to have a dedicated after-hours message service, it is technically feasible.
Page 5, Comments and Recommendations	Based on industry standards, EUTF should consider increasing their contract guarantees for turnaround time to 95% within 14 calendar days. They should also consider initiating a 97% performance guarantee, with monetary penalty, for Payment Accuracy to further enhance claim control measures.	N/A – Recommendation to EUTF.
Page 5, Comments and Recommendations	In consideration of the Plan's change to a self-funding arrangement effective July 2007, HMSA and EUTF should discuss implementation of a look-back period and dollar threshold to pursue overpayments for retroactive terminations.	Looking forward to when EUTF has a self-funded arrangement, HMSA and EUTF will work together to identify a process which will address retroactive terminations.
Page 5, Comments and Recommendations	EUTF should consider establishing annual requests for COB information on a 12-month rolling basis with mandatory employee response requirements to ensure industry best practice is followed once self-insured.	We would support this as we are currently not receiving any COB information on the enrollment file submitted by EUTF.
Page 5, Comments and Recommendations	HMSA should implement procedures to update the member's calendar year out-of-pocket when a Blue Card (out-of-state) claim is originally processed to prevent excess member liability.	The BlueCard Program allows members to receive services from the Blue Network at a discount, which result in substantial savings to EUTF. A delay in updating the member's claims history and associated co-pay/co-insurance accumulators is an inherent risk in the BlueCard program. We will look for ways to reduce the lag time in posting out-of-area claims.
Page 5, Comments and Recommendations	HMSA and EUTF should discuss procedures for advance and ongoing notification of pending large dollar hospital claims to ensure management	Large dollar hospital claims are currently reported to EUTF on an annual basis. Looking forward to

	reports and advance funding considerations are addressed under the Fund's upcoming self-funding arrangement.	when EUTF has a self-funded arrangement, we can discuss procedures so that hospitals will provide advance and ongoing notifications.
Page 5, Comments and Recommendations	HMSA should extend their $100.00 threshold to suspected fraud and duplicate payments; reduction through current benefits payable should be considered for refusal or non-response to refund requests.	It appears that this statement was misinterpreted. The $100 threshold is already in place for all payment errors, including suspected fraud and duplicate payments. Anything under the $100 threshold may be pursued at management's discretion. We also would like to receive clarification on what does reduction through current benefits payable mean. (Need to also modify verbiage on page 18, section titled "Overpayment Recovery" first paragraph, third sentence).
Page 6, Comments and Recommendations	EUTF should consider a system parameters review to confirm benefit design accuracy on HMSA's new system prior to or immediately following live claims processing	Accuracy of the benefit design is reviewed by operations as well as continuously monitored by the MTM audits. It is EUTF's discretion, if they want to consider a system parameters review.
Page 6, Comments and Recommendations	Underpayments identified in this review should be reopened and additional payment sent to the member and/or provider with explanation. Overpayment recovery should be initiated based on HMSA's $100.00 threshold.	We are in the process of correcting the underpayments/ overpayments identified in the review based on our guidelines.
Page 6, Comments and Recommendations	HMSA should advise EUTF of confirmed duplicates based on findings of Segal's electronic analysis and onsite review; overpayment recoveries should be implemented per HMSA's internal procedures.	We are continuing with our analysis of the potential duplicate findings.
Page 6, Comments and Recommendations	HMSA should define allergy test series codes for the processing system to identify and deny services that exceed the Plan's annual maximum (*e.g.*, one series of tests per year).	We will analyze the benefit of a front-end edit check versus a back-end review for the allergy test series codes.
Page 6, Comments and Recommendations	EUTF should consider a follow-up audit within six months from the group's transition to a self-funded arrangement to ensure consistency of administrative services	N/A – Recommendation to EUTF.
Page 6, Comments and Recommendations	HMSA should advise EUTF of any change in procedures resulting from this review as well as resolution of the payment errors addressed in this report.	We will inform EUTF of final resolutions of identified payment errors.