UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Management Decisions and Final Actions on the Office of the Inspector General's Audit Recommendations October 1, 2011 - March 31, 2012

Director's Semiannual Report to the Congress

a New Day for Federal Service

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
MAY 2012

MESSAGE FROM THE DIRECTOR

Introduction

The United States Office of Personnel Management's (OPM) Office of the Inspector General (OIG) has completed its Semiannual Report for the period of October 1, 2011, to March 31, 2012. Working alongside the OIG during this period, OPM made progress in many important areas. I am transmitting the report to the U.S. Congress as required by law, along with the OPM management response containing additional information to explain how we have worked with the OIG to make improvements.

Accomplishments

OPM is focused on its mission—to recruit, retain, and honor a world-class workforce to serve the American people. We accomplish this mission by supporting agencies with personnel services and policy leadership including staffing tools, guidance on labor-management relations, and programs to improve workforce performance. Our accomplishments these past six-months clearly demonstrate that we remain focused on our mission.

Among the highlights:

Retirement Claims Processing

As I pledged to Congress on November 15, 2011, my highest priority this year is fixing the unacceptable and systemic delays Federal employees face in retirement claims processing. On January 17, 2012, OPM issued a strategic plan[1] to increase the number of retirement processing staff; streamline processes; cooperate better and exchange data with other agencies; and improve information technology. We rehired eight experienced retirees to process claims to improve productivity, granted overtime to processing specialists who proved they can swiftly and accurately adjudicate claims, and reassigned

[1] United States Office of Personnel Management Strategic Plan for Retirement Services, January 17, 2012. http://www.opm.gov/StrategicPlan/pdf/StrategicPlanforRetirementServices.pdf.

the administrative duties of our specialists so they can concentrate on processing claims. Due to these efforts and an "all hands on deck" approach, I'm proud to say that we've already achieved significant progress in reaching our goals. In March, OPM processed 12,386 pension claims, a 40 percent increase in monthly processing since we began tracking numbers in January. By March, our backlogged claims dropped to 52,274, lower than the 55,378-claim backlog we originally expected.

Diversity and Inclusion

OPM leads the government-wide diversity and inclusion initiative to assist agencies as they seek to recruit, retain, and develop talented individuals from all communities. In March, Federal agencies submitted Diversity and Inclusion Strategic Plans pursuant to Executive Order (EO) 12583, "Establishing a Coordinated Government-Wide Initiative to Promote Diversity and Inclusion in the Federal Workforce" (August 2011). OPM is currently providing agencies with feedback on these plans to ensure they are aligned with the government-wide strategic plan and agency missions. OPM is also assisting agencies as they implement OPM-developed model strategies on the recruitment and hiring of individuals with disabilities through Schedule A hiring authority. Further, OPM created a database with qualified Schedule A candidates with disabilities, provided training to over 2,000 Federal employees regarding Schedule A hiring authority and reasonable accommodation, and developed a community of practice for agency personnel to share leading practices.

Pre-existing Conditions Insurance Plan

OPM partners with the U.S. Department of Health and Human Services to run the Pre-Existing Condition Insurance Plan (PCIP) to provide lifesaving healthcare coverage to Americans with conditions that would preclude insurance coverage in the private market. OPM also provides oversight and assistance to the U.S. Department of Agriculture's National Finance Center to administer plan enrollment. As the administrative contracting office with the Government Employees Health Association (GEHA), the third party administrator of PCIP, OPM provides oversight on administrative activities, including claims processing and dispute resolution and provider network management. OPM has worked with GEHA to control costs, create the plan brochure and website, and provide outreach to potential enrollees.

We are exceedingly pleased that during 2011, PCIP enrollment grew over 566% and continues to grow today. The plan provides cost-effective care to Americans who need it badly, including transplant recipients and newborn babies, and creates a bridge to January 1, 2014, when health insurance plans will no longer be able to deny enrollment or coverage based on pre-existing conditions.

OPM's Response to the Inspector General's Findings

While I am proud of our many achievements, I am keenly aware we must also continue to strengthen our programs. The Inspector General's report highlights key challenges for OPM in the months ahead. OPM is focused on eliminating any weaknesses in our programs, for example:

Information Security

The IG notes that OPM implemented a decentralized information security model in which designated security officers (DSOs) of major systems are appointed by and report to the program offices that own the systems. During the last six months, the Chief Information Officer (CIO) has consolidated information security within OPM. DSOs responsible for critical IT systems—including USAJOBS, USASTAFFING, and Employee Express—now report directly to the CIO. Additionally, the CIO provides written performance reviews for those DSOs who do not report directly to the CIO. In the next phase, the CIO will manage additional DSO functions. Our goal is to have all information security at OPM centralized under the CIO by the first quarter of FY 2013.

Combined Federal Campaign (CFC) Oversight

This report details an OIG audit of the National Capital Area (NCA) Combined Federal, in which Campaign Global Impact, the non-profit entity serving as the administrator of the campaign, failed to adequately document expenses and failed to comply with OPM regulations by improperly expending campaign funds for certain travel expenses, meals, and other costs not beneficial to the campaign.

OPM immediately responded by directing Global Impact to return all disallowed costs and initiating new accountability and oversight measures. As a result, Global Impact has already reimbursed the campaign for all disallowed expenses and agreed to implement additional internal controls and policies specified by OPM. In addition, OPM put in place a new task force group, led by the watchdog organization Charity Navigator, to look at the potentially wasteful expenditures identified by the IG. This task force is part of a broader CFC commission already created by OPM to identify ways to increase accountability and transparency in the CFC, co-chaired by former members of Congress Tom Davis and Beverly Byron. Lastly, OPM issued a directive to all non-profit entities associated with the CFC prohibiting the use of campaign funds for meals and entertainment in any circumstances.

As the Federal agency responsible for overseeing the CFC across the nation and around the world, OPM is committed to ensuring that charitable contributions made by Federal employees and service members are properly administered, with the maximum amount reaching charities. Any failure to abide by OPM regulations regarding the handling of charitable contributions is unacceptable.

Federal Employees Health Benefits Program (FEHBP)

The IG's message outlines two proposals to control FEHBP costs by recovering improper payments and improving the collection of fines, penalties, and other damages. We are committed to working on the identified issues and further discussions with the IG regarding this important matter.

Closing Remarks

The OIG has helped OPM address identified weaknesses and strengthen our programs. I want to thank the OIG staff for continuing to provide independent review of OPM activities, helping us better serve the American people.

Sincerely,

John Berry
Director

MANAGEMENT RESPONSE

TO THE INSPECTOR GENERAL'S SEMIANNUAL REPORT

TO CONGRESS

May 2012

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HEALTH, LIFE and INDIVIDUAL BENEFITS AUDITS

More than 8 million lives are covered by the Federal Employees Health Benefits Program (FEHBP), Federal Employees' Group Life Insurance (FEGLI), Federal Flexible Spending Account Program (FSAFeds), Federal Employees Dental and Vision Insurance Program (FEDVIP) and the Federal Employees Long Term Care Insurance Program (FLTCIP). These programs provide important benefits and impact current and former federal employees and their families. Together they form a key component of the federal government's compensation package, helping agencies recruit, retain and honor a world class workforce. Effective administration of these programs requires balancing resources to meet consumer expectations through our partnership, oversight and compliance efforts. Healthcare and Insurance remains committed across all aspects of its stewardship responsibilities in administering the benefit programs to the federal family.

AUDIT RESOLUTION

Federal Employee Insurance Operations' (FEIO) Audit Resolution (AR) team reconciles monetary and non-monetary audit findings identified by the Office of the Inspector General (OIG) in its audits of the FEHBP, FEGLI, FSAFeds, LTC and FEDVIP programs. Additionally, AR facilitates the resolution of Government Accountability Office (GAO), Internal Oversight and Compliance (IOC) and other audits or reviews of HI programs. To maximize timely, fair and accurate resolution, work begins before the OIG releases a final audit report. Key stakeholders evaluate DRAFT findings to reduce potentially avoidable or time-consuming procedural and regulatory challenges. AR determines the amounts due the Federal Programs, recovers funds, and works with carriers, Contract and OPM officials to implement corrective actions and close the audit. Resolution (the determination of a receivable due the FEHBP) and the completion of post-resolution corrective actions (report closure) remain a high priority. While each audit requires a slightly different approach, closing audits entails collaboration among the Contract Officer (CO), OIG, health plans, Office of the Actuary – for HMO's only-- and, on occasion, OPM's General Counsel or counsel from the Plan. AR reviews audit findings, supporting spreadsheets and documentation from the OIG, and evaluates the Plan's written responses, spreadsheets and other evidence including health benefits claim data. Audit Resolution also references the appropriate Contract (e.g. CS 1039), Federal Acquisition Regulation (FAR) or Rate/Reconciliation Instruction language, and solicits input and opinions from the Health Insurance Contract Officers, the OIG, the Plan(s), and the Office of the Actuary.

Each audit is unique. A Plan's response to a monetary finding may indicate their agreement or disagreement with the finding. Overpayments may be repaid by check, by certifying that funds have been returned to the FEHB, or via Letter-Of-Credit transaction/adjustment. A plan may agree with an overpayment but, after unsuccessfully attempting to collect it, declare it to be uncollectible or may contest it based on other circumstances. Plan responses may also contest audit findings by describing errors, oversight or other extenuating circumstances it believes are at play, or may question the interpretation of contract language in support of its actions.

Plan responses, which may be accompanied by voluminous evidence, must be reviewed in detail. Such due process prolongs final resolution and appropriate corrective actions.

A plan's agreement with a finding, or concurrence that an overpayment was made, does not necessarily mean that monies can or will be collected. Plans are contractually required to exercise due diligence in recovering overpayments and provide updates on their progress in remediating audit findings. Factors contributing to timely, successful closure of findings within a final audit report may include: prompt, diligent action by Plans to recover overpayments and resolve findings; appropriate resourcing; effective internal controls; age of overpayment when audited; and interpretation of contract provisions and other subsidiary laws or agreements in place.

During this reporting period, FEIO continued to focus on closing aged audit recommendations. Insurance Operations (IO), including Contracting Officers and Audit Resolution staff:

- Collaborated with key stakeholders and Plans to fully resolve 12 open audits
- Recovered over $10.0 million and appropriately allowed $3.3 million
- Continued to standardize procedures for resolving most audits within 180 days
- Expanded AR's scope in reporting and internal control activities
- Sought legal counsel and guidance for the most difficult resolutions
- Recruited additional staff to improve responsiveness to audits

Under our new configuration, contracting staff is taking a more active role in their oversight responsibilities through continuous involvement in the entire IG audit process.

Healthcare and Insurance welcomes collaboration with the OIG to ensure that participating plans have strong Internal Controls in place, and that our Contracting Officers (CO) provide effective oversight and administration of these vital benefit programs. FEIO and OIG leadership are partnering to develop new, and strengthen existing, procedures to resolve audits in a manner that is clear, supportable and reflects the many factors that must be considered in resolving this class of audit findings.

Contracting Officers' discretion is a key aspect of IO's oversight of the Benefit Programs. Collaborating with all stakeholders, including OIG, CO's must consider many technical, cost, and performance issues in appropriate audit resolution actions, including the closure of audit recommendations. The CO weighs not only the nature and severity of audit findings, but also costs to the program and reasonable timeframes for remediation. Further, the size and reach of a benefit plan and the possible impacts on participants, some of whom reside in areas underrepresented by health care providers and options. In this context service availability and pragmatic considerations, may prove pivotal in deciding to require implementation of an audit finding.

We began this period with 5 audit reports pending agency decisions totaling $9.7 million. The OIG issued 17 new reports with unresolved monetary findings totaling $22.9 million, bringing the work-in-progress to $32.7 million under 22 audit reports. IO Management's decisions on OIG recommendations during this period were $19.4 million covering 13 audit reports. This amount is a combination of $19.5 million in "disallowed costs" (requiring payment to OPM) and a net **(**$.08**)** million in "costs not disallowed" (payment to OPM not required). The balance at the end of the period totals $13.3 million pertaining to 9 audit reports.

RECOVERY AND ADJUSTMENTS TO DISALLOWED COSTS

FEIO and AR continue to be productive. Prior to the reporting period, AR resolved 10 audits (agreed with the auditor's questioned costs and set up Accounts Receivables) representing $59 million to be collected from insurance carriers. AR will close these audits as funds are received and pertinent documentation that satisfactorily addresses non-monetary recommendations, uncollectible and plan-contested amounts is verified.

During the reporting period, resolutions were made on 14 additional audits representing $19.3 million to be collected from insurance carriers. Total interest accrued during the reporting period was $309 thousand. This totals 24 audits with monetary recommendations representing $78.6 million. As of March 31, we recovered $10 million and made adjustments to original debt of $3.3 million in 22 of the 24 audits. The remaining 2 audits were pending action at the end of the reporting period. The total Receivable for all open audits as of the end of the reporting period was $65.3 million.

AR successfully closed 12 FEHB audit reports during the 6 month reporting period. For the 12 month period, April 1, 2011 – March 31, 2012, AR closed 24 audits, recovering $55.1 million and appropriately allowing another $12.0 million for a total of $67.0 million. As a result, the average age of audits greater than one year old decreased by over 25% when compared to aged audits 12 months ago. These results were made possible through enhanced collaboration with both internal and external stakeholder groups (OIG, Office of the Actuary, Health Plans and others).

Review and development of corrective action plans will continue to be integral to our oversight, compliance and monitoring of the operations of contracts.

AUDITS OVER ONE YEAR OLD PENDING CORRECTIVE ACTION AND FINAL CLOSURE

Audit Resolution is working to reduce the number of aged BlueCross BlueShield audits pending final closure. The audits listed below are receiving special attention as we work to address the issues in each. Details on open recommendations have been reported in prior Semiannual and Management Response Reports and Health Plans have been informed of corrective actions that must be taken, although actions have not yet been completed.

BlueCross and BlueShield Audits

Report Date	Audit Number	Status	Audit Name
6/23/2009	1A-99-00-08-065	Corrective Action Pending	Global Enrollment Audit (2008)
7/20/2009	1A-99-00-09-011	Corrective Action Pending	Global Coordination of Benefits (FY 2009)
10/14/2009	1A-99-00-09-036	Corrective Action Pending	Global Duplicate Payments
03/30/2010	1A-99-00-09-061	Corrective Action Pending	Global Assistant Surgeon
03/31/2010	1A-99-00-10-009	Corrective Action Pending	Global Coordination of Benefits (FY 2010)

HMOs, another class of audits, generally involve complex calculations related to the methodology used to establish rates for Similarly Sized Subscriber Groups (SSSG). The SSSG methodology is then used to verify whether the FEHB Program received correctly discounted rates. Disputes regarding interpretation of the guidance used by plans to identify SSSGs can lead to protracted and complex standoffs involving legal issues, and the resolution may require coordination and action between the CO, the OIG, the Office of the Actuary, Audit Resolution and the Office of the General Counsel. Actions required to resolve these audits vary by level of complexity. The CO may evaluate the need for amending contract language and must also collaborate with the Actuaries and the OIG to improve clarity and plans' understanding of the Rate Instructions.

In 2012, OPM began transitioning to the use of a Medical Loss Ratio (MLR) for Non-Traditional Community Rated plans, as a replacement for an examination of Similarly Sized Subscriber Groups in determining whether the FEHB received competitive rates from HMO plans. The MLR methodology uses a ratio of incurred claims to earned premiums over a specific period as opposed to a detailed examination of the rates, benefits, discounts and premiums used by a SSSG. For Contract year 2012, OPM has a pilot program for the new MLR methodology. By 2014, OPM will fully implement MLR for Non-Traditional Community Rated Plans. Use of the MLR is expected to simplify the process and may make it easier to implement, document, audit and resolve.

Other Insurance Carriers

Report Date	Audit Number	Status	Audit Name
1/18/2008	1C-3U-00-05-085	Corrective Action Pending	United HealthCare of Ohio
6/12/2008	1C-G2-00-07-044	Corrective Action Pending	Arnett HMO Health Plan
3/26/2009	1B-45-00-08-16	Corrective Action Pending	Coventry Health Care / MHBP
04/14/2010	1B-45-00-09-062	Corrective Action Pending	Coventry Health Care / MHBP

Overall, as of this report there is a total of $14.3 million outstanding pertaining to audits for which full Recoveries and Corrective Actions were not completed within one year. Contractually, Carriers must follow standard business practices and make diligent efforts to collect overpayments. However, until the funds have been recovered, or it has been determined that the funds are uncollectible and must be written-off, the receivable must remain on OPM's book of record. With few exceptions our new emphasis on more timely resolutions (with greater focus on resolving issues during an audit's draft phase) should shorten and simplify the overall resolution process. Significantly, it will also better allow audit reports to be used as a tool to enhance management's oversight and carrier's compliance.

The following information provides a summary of collection and adjustment activity for the period October 1, 2011 to March 31, 2012.

MANAGEMENT REPORT ON FINAL ACTION ON AUDITS WITH DISALLOWED COSTS *Reporting Period Ending March 31, 2012***

Action	Number of Audit Reports	Disallowed Costs (in thousands)
A. Audit reports with management decisions on which final action had not been taken at the beginning of the period (10/1/2011)	10	$58,984
B. 1. Audit reports on which management decisions were made during the period (10/1/2011-3/31/2012)	14	$19,339
2. Interest assessed during period	0	$309
C. Total audit reports pending final action during period (total of A and B)	**24**	**$78,632**
D. Audit reports on which final action was taken during the period		
1. Recoveries		
(a) Collections and offsets	**22**	**$10,040**
(b) Property	**0**	**0**
(c) Other	**0**	**$3,335***
2. Write-offs, waiver	**0**	**0**
3. Total of 1 and 2	**22**	**$13,375**
E. Audit reports needing final action at the end of the period (3/31/2012) (subtract D3 from C)	**2**	**$65,257**

* This represents adjustments to original debt.

**Information from the preceding tables is provided by the CFO and derived from OPM's Audit Report and Receivables Tracking System (ARRTS). Amounts reported may not fully reconcile due to actions taken on Information System and Non-Monetary audit reports as well as monetary reports with non-monetary recommendations

***Row descriptions, clarified

A. – # of audit reports with monetary recommendations for which an Accounts Receivable was *previously* set up, however, audit(s) are not fully closed.

B. – # of audit reports with monetary recommendations for which an Accounts Receivable was set up *during* the SAR period

C. – Total # of audit reports with monetary recommendations pending final recoveries and audit closeout

D. – # of audit reports with monetary transactions during the SAR period

E. – # of audit reports with monetary recommendations awaiting the set up of an Accounts Receivable at the end of the period. Typically these are audits issued just prior to the end of the SAR period

STATUS OF THE INSURANCE AUDITS HIGHLIGHTED IN THE OFFICE OF THE INSPECTOR GENERAL'S SEMIANNUAL REPORT (resolution activity for audits released from October 1, 2011, through March 31, 2012)

REPORT, REPORT NUMBER, AND DATE	STATUS
Humana Health Plan of Texas, Inc. Louisville, KY 1C-UR-00-11-013 November 9, 2011	CLOSED -- All outstanding issues have been resolved
Grand Valley Health Plan, Inc. Grand Rapids, MI 1C-RL-00-11-042 March 13, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.
Global Duplicate Claim Payments for Blue Cross and Blue Shield Washington, D.C. 1A-99-00-11-022 January 11, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.
Global Coordination of Benefits for Blue Cross and Blue Shield Washington, D.C. 1A-99-00-11-055 March 28, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.
Government Employees Health Association, Inc. Benefit Plan Lee's Summit, MO 1B-31-00-10-038 March 12, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.
Information Systems General and Application Controls at BlueCross BlueShield of South Carolina Columbia, SC 1A-10-24-11-014 November 9, 2011	Under review. We are evaluating all outstanding issues and expect to initiate Corrective Actions.
BlueCross BlueShield Association's Federal Employee Program Portability System Columbia, SC & Wilmington, DE 1A-10-00-12-022 February 2, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.

REPORT, REPORT NUMBER, AND DATE	STATUS
Information Systems General and Application Controls at Medco Health Solutions, Inc. Franklin Park, NJ 1A-10-00-11-052 March 14, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.
Federal Long Term Care Insurance Program Operations Portsmouth, NH 1G-LT-00-10-022 November 10, 2011	Under review. We are evaluating all outstanding issues and expect to initiate Corrective Actions.
Federal Employees Dental and Vision Insurance Program Operations as Administered by the Office of Personnel Management Washington, D.C. 1J-0L-00-11-033 February 1, 2012	Under review. We expect to resolve all issues and/or initiate Corrective Actions in a timely manner.

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