

OCTOBER 1, 2011
through
MARCH 31, 2012

SEMIANNUAL REPORT *to* CONGRESS



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General

OFFICE OF THE INSPECTOR GENERAL



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$23,313,937
Management Commitments to Recover Funds	\$19,487,932
Recoveries Through Investigative Actions	\$3,563,333

Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

ACCOMPLISHMENTS:

Audit Reports Issued	41
Evaluation Reports Issued	1
Investigative Cases Closed	40
Indictments and Informations.	32
Arrests.	24
Convictions	22
Hotline Contacts and Preliminary Inquiries Complaints.	924
Health Care Provider Debarments and Suspensions	354
Health Care Provider Debarment and Suspension Inquiries	1,881

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**SEMIANNUAL
REPORT**
to
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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

**Office of the
Inspector General**



Inspector General's Message

It is widely accepted that rising costs of health care and health insurance are among the most significant challenges currently facing the country. Our office, for which audit and investigative oversight of the Federal Employees Health Benefits Program (FEHBP) represents a principal component of our responsibility, is deeply concerned with this trend. Our work focuses on enhancing the efficiency and integrity of the FEHBP through avoiding unnecessary costs, recovering improper payments, and protecting the program and its enrollees through investigation and prosecution of fraud and abuse. We also continually seek to leverage our “grass roots” experience to develop recommendations – addressing both administrative practices and needs for legislative action – that would contribute to holding the line on costs while improving the quality of health care provided to enrollees. In this message, we are highlighting two proposals which *would cost nothing to implement*, but would in fact recover money improperly paid out by the FEHB and would improve the collection of fines, penalties, and additional damages that are paid by wrongdoers.

The first proposal addresses administrative measures to ensure that the FEHBP carriers actually do what they are already being paid to do. By contract, OPM requires each health carrier to implement fraud prevention measures by establishing a Fraud and Abuse (F&A) Program. The costs of complying with this requirement are of course chargeable to the FEHBP trust funds. Our office has been concerned for some time that health carriers have not been performing these responsibilities effectively. During the past year, we launched a series of innovative special reviews in which our investigators and auditors examined the F&A Programs of three large FEHBP insurance carriers concurrently with the regularly-scheduled audits of those carriers. The reviews examined the F&A Program plans developed by the carriers as well as the actual execution of them. The final reports of two of these audits were issued during the current reporting period.

The investigators and auditors found that the effectiveness of the F&A Programs was questionable. The programs’ outcomes, in terms of the prosecution of fraud cases and recovery of defrauded funds, were minimal. The reviewers concluded that the costs charged to FEHBP – in the tens of millions of dollars annually – were not achieving the desired results.

We are now approaching this issue as a systemic problem that exists throughout the FEHBP, and have intensified our work in this area. To date we have completed either full reviews or preliminary



Inspector General's Message

analyses of the F&A Programs of carriers that account for approximately 90 percent of FEHBP costs, and are concerned that carriers are being paid to conduct activities that produce minimal results for the FEHBP. The F&A Programs were conceived as the cornerstones of the FEHBP's fraud detection efforts, and a minimal return on investment in this area is very troubling.

Health carriers must be held accountable for how they spend FEHBP funds. To do this, OPM needs to assert a stronger role in expanding and enforcing the fraud-prevention provisions in carrier contracts. Our office is working with the agency to establish specific performance and reporting requirements for F&A Programs. Further, we will continue combining our investigative and audit capabilities to assess the effectiveness of these programs and to assure that the FEHBP is truly getting the level of service for which it is being charged.

A second proposal that my office is pursuing is an amendment to the Anti-Kickback Statute. This statute makes it illegal for health care providers, including doctors, to knowingly and willfully accept bribes or other forms of remuneration in return for generating business under a Federal health care program – except for the FEHBP.

The FEHBP was not simply overlooked or left out – it was specifically excluded from the Anti-Kickback Statute. Consequently, activities that constitute criminal behavior when committed under any other Federal health care program are not punishable if they occur within the FEHBP. This means that it is not illegal for doctors to subject Federal workers, retirees, and their families to potentially unnecessary or harmful medical procedures in return for a gratuity or kickback. There is also a related, negative impact on the integrity of the FEHBP itself, as prosecutors who are pursuing cases under the Anti-Kickback Statute are often reluctant to expand their cases to include similar False Claims Act violations against the FEHBP by the same providers. Thus, we are rendered less able to protect the FEHBP against violations by providers, even when there may be a meritorious basis for legal action.

We find it unacceptable that the health of the 8 million FEHBP enrollees is apparently less valued than that of participants in Medicare, Medicaid, TRICARE, and other Federal health care programs. Similarly, it is illogical that the Federal funds paid into the FEHBP receive less protection from improper practices by health care providers than those spent on other Federal health care programs. Aside from the impact upon patient health and safety, unnecessary medical procedures contribute to the rising costs of health care, including increases in FEHBP premiums.

To address these inequities, my office has developed a legislative proposal to amend the Anti-Kickback Statute to include coverage of the FEHBP. The simple removal of the 15 words that exclude the FEHBP from the statute is all that it would take to provide equal protection to Federal workers, retirees, and their families, as well as protect valuable tax dollars spent on the program.

We are living in a time when the Government is seeking ways to reduce its spending and fighting to keep health care costs from skyrocketing. These two proposals would help the Government achieve both of these goals while also protecting the health of approximately 8 million people – **all without spending a dime.**

A handwritten signature in green ink that reads "Patrick E. McFarland".

Patrick E. McFarland
Inspector General



Mission Statement

Our mission is to provide independent and objective oversight of OPM services and programs.

WE ACCOMPLISH OUR MISSION BY:

- Conducting and supervising audits, evaluations and investigations relating to the programs and operations of the U.S. Office of Personnel Management (OPM).
- Making recommendations that safeguard the integrity, efficiency and effectiveness of OPM services.
- Enforcing laws and regulations that protect the program assets that are administered by OPM.

Guiding Principles

WE ARE COMMITTED TO:

- Promoting improvements in OPM's management and program operations.
- Protecting the investments of the American taxpayers, Federal employees and annuitants from waste, fraud and mismanagement.
- Being accountable to the concerns and expectations of our stakeholders.
- Observing the highest standards of quality and integrity in our operations.

Strategic Objectives

THE OIG WILL:

- Combat fraud, waste and abuse in programs administered by OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM complies with applicable Federal regulations, policies and laws.
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws and regulations.
- Aggressively pursue the prosecution of illegal violations affecting OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.



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Field Offices





Audit Activities

Health Insurance Carrier Audits

The United States Office of Personnel Management (OPM) contracts with private sector firms to provide health insurance through the Federal Employees Health Benefits Program (FEHBP). Our office is responsible for auditing the activities of this program to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 220 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or health insurance plan mergers and acquisitions. The premium payments for the health insurance program are over \$35 billion annually.

The health insurance plans that our office audits are either community-rated or experience-rated carriers.

Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs).

Experience-rated carriers are mostly fee-for-service plans, the largest being the BlueCross and BlueShield health plans, but also include experience-rated HMOs.

The two types of carriers differ in the way they calculate premium rates. Community-rated carriers generally set their rates based on the average revenue needed to provide health benefits to each member of a group. Rates established by experience-rated plans reflect a given group's projected paid claims, administrative expenses and service charges for administering a specific contract.



During the current reporting period, we issued 24 final audit reports on organizations participating in the FEHBP, of which 15 contain recommendations for monetary adjustments in the amount of \$22.0 million due the OPM administered trust funds.

Community-Rated Plans

The community-rated HMO audit universe covers approximately 120 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable Federal laws and regulations.

Federal regulations require that the FEHBP rates be equivalent to the rates a plan charges the two groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups* (SSSGs). The rates are set by the plan, which is also responsible for selecting the two appropriate groups. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Community-rated audits focus on ensuring that:

- The plans select and rate the appropriate SSSGs;
- The FEHBP rates are equivalent to those charged the SSSGs; and,
- The loadings applied to the FEHBP rates are appropriate and reasonable.

Loading is a rate adjustment that the FEHBP makes to the basic benefit package offered by a community-rated plan. For example, the FEHBP provides coverage for Federal annuitants. Many Federal annuitants may also be enrolled in Medicare. Therefore, the FEHBP rates may be adjusted to account for the coordination of benefits with Medicare.

During this reporting period, we issued 14 final audit reports on community-rated plans. These reports contain recommendations that require the health plans to return over \$3.9 million to the FEHBP.

Humana Health Plan of Texas, Inc.

LOUISVILLE, KENTUCKY

Report No. 1C-UR-00-11-013

NOVEMBER 9, 2011

Humana Health Plan of Texas, Inc. provides comprehensive medical services to its members in the San Antonio, Austin, and Corpus Christi areas of Texas. This audit of the plan covered contract years 2008 through 2010. During the period, the FEHBP paid the plan approximately \$181.3 million in premiums.

Inappropriate Charges Amount to \$541,470

We identified \$541,470 in inappropriate health benefit charges to the FEHBP in 2008 and 2010. In addition, we determined the FEHBP is due \$53,876 for investment income lost as a result of the overcharges.

Lost investment income represents the potential interest earned on the amount the plan overcharged the FEHBP as a result of defective pricing.

The overcharges occurred because the plan did not apply the largest SSSG discount to the FEHBP rates.



Grand Valley Health Plan, Inc.

GRAND RAPIDS, MICHIGAN

Report No. 1C-RL-00-11-042

MARCH 13, 2012

Grand Valley Health Plan, Inc. provides comprehensive medical services to its members throughout the Grand Rapids area of Michigan. This audit of the plan covered contract years 2006 through 2010. For contract years 2008 and 2009, we determined that the plan's rating of the FEHBP was in accordance with the applicable laws, regulations, and the OPM's rating instructions. During the period, the FEHBP paid the plan approximately \$32.5 million in premiums.

The audit identified \$1,028,936 in inappropriate health benefit charges to the FEHBP in contract years 2006, 2007, and 2010. In addition, we determined the FEHBP is due \$200,888 for

investment income lost as a result of the overcharges.

**Overcharges
Amount
to Over
\$1 Million**

The FEHBP was overcharged because the plan did not apply the largest SSSG discount to the 2006 and 2010 FEHBP rates and various errors occurred in its rate calculations for contract years

2006, 2007, and 2010.

Experience-Rated Plans

The FEHBP offers a variety of experience-rated plans, including a service benefit plan and health plans operated or sponsored by Federal employee organizations, associations, or unions. In addition, experience-rated HMOs fall into this category.

The universe of experience-rated plans currently consists of approximately 100 audit sites. When auditing these plans, our auditors generally focus on three key areas:

- Appropriateness of FEHBP contract charges and the recovery of applicable credits, including refunds;
- Effectiveness of carriers' claims processing, financial and cost accounting systems; and,
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued nine experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$17.7 million in inappropriate charges and lost investment income to the FEHBP. A summary of three final reports is provided to highlight our notable audit findings.

BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield Association (Association), which administers a fee-for-service plan known as the Service Benefit Plan, contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective Federal subscribers and report their activities to the national BlueCross BlueShield (BCBS) operations center in Washington, D.C. Approximately 60 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued eight BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors identified \$16.5 million in questionable costs charged to the FEHBP contract. The BCBS agreed with \$8.1 million of the identified overcharges.

Audit Activities



Global Duplicate Claim Payments for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-11-022

JANUARY 11, 2012

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to duplicate claim payments. Duplicate claim payments are services or claim lines that were charged twice or multiple times to the FEHBP.

Our auditors performed multiple computer searches on the BCBS claims database to identify potential duplicate

FEHBP Overcharged \$6.3 Million for Duplicate Claim Payments

payments on claims that were paid during the period January 2008 through December 2010. We identified 6,592 duplicate claim payments, and found that 62 of the 63 plan sites made duplicate payments. We also noted that

the BCBS national claims system did not identify approximately 50 percent of these claims as potential duplicates.

As a result, we determined that the FEHBP was overcharged \$6,342,749 for these duplicate claim payments. The BCBS agreed with \$5,337,343 of the questioned overcharges.

Global Coordination of Benefits for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-11-055

MARCH 28, 2012

We performed a limited scope performance audit to determine whether the BCBS plans complied

with contract provisions relative to coordination of benefits (COB) with Medicare.

Coordination of benefits occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays its benefits as the primary payer and the other insurer pays a reduced benefit as the secondary payer. Medicare is usually the primary payer when the insured is also covered under an FEHBP plan.

Using our data warehouse, we performed a computer search on the BCBS claims database to identify payments for services that were paid from July 2010 through April 2011 and potentially not coordinated with Medicare. We determined that 57 of the 63 plan sites did not properly coordinate payment charges with Medicare. As a result, the FEHBP incorrectly paid claims when Medicare was the primary insurer because no information existed in the BCBS national claims system to identify Medicare as the primary payer. After the Medicare information was added to the payments system, the BCBS plans did not adjust the patients' prior payments retroactively to the Medicare effective dates.

FEHBP Overcharged \$8.9 Million for Coordination of Benefits Errors

Consequently, these costs continued to be charged entirely to the FEHBP. The BCBS incorrectly paid these claims despite retroactive adjustments on over 40 percent of the 13,447 claim payments questioned. Of the remaining claims questioned, the BCBS plans incorrectly paid these claims due to manual or systematic processing errors.

We determined that the FEHBP was overcharged \$8,898,131 for these COB errors. The BCBS agreed with \$1,529,042 and disagreed with \$7,369,089 of the questioned claim overcharges. Most of the contested amount represents COB



errors where recovery efforts were already initiated by the BCBS plans before receiving our audit request (i.e., sample of potential COB errors). However, since the plans had not recovered and returned these overpayments to the FEHBP by the end of our audit scope, we continued to question these overpayments in the final report.

Employee Organization Plans

Employee organization plans fall into the category of experience-rated plans. These plans either operate or sponsor participating Federal health benefits programs. As fee-for-service plans, they allow members to obtain treatment through facilities or providers of their choice.

The largest employee organizations are Federal employee unions and associations. Some examples are the: American Postal Workers Union; Association of Retirees of the Panama Canal Area; Government Employees Health Association, Inc.; National Association of Letter Carriers; National Postal Mail Handlers Union; and, Special Agents Mutual Benefit Association.

We issued one employee organization plan audit report during this reporting period for the Government Employees Health Association, Inc. Benefit Plan.

Government Employees Health Association, Inc. Benefit Plan

LEE'S SUMMIT, MISSOURI

Report No. 1B-31-00-10-038

MARCH 12, 2012

The Government Employees Health Association, Inc. Benefit Plan (Plan) is an experience-rated employee organization plan. Specifically, this Plan is a fee-for-service health plan with a preferred provider organization (PPO). Enrollment is open

to all Federal employees and annuitants who are eligible to enroll in the FEHBP and who are, or become, members of the Government Employees Health Association, Inc. (GEHA). GEHA is the underwriter, sponsor and administrator of the Plan. Members have a choice of enrollment in High Option or Standard Option.

**GEHA
Agrees with
\$1.1 Million
in Questioned
Health Benefit
Charges**

The audit of the Plan's FEHBP operations covered claim payments from January 2007 through May 2010, as well miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2006 through 2009. For contract years 2006 through 2009, the Plan processed approximately \$6.7 billion in FEHBP health benefit payments and charged the FEHBP \$323 million in administrative expenses.

Our auditors questioned \$1,177,068 in health benefit charges and also identified procedural findings regarding the Plan's PPO network pricing oversight and Fraud and Abuse Program.

The monetary findings included the following:

- \$477,858 in net overpayments due to claim pricing errors;
- \$414,700 in overpayments because claims were not properly coordinated with Medicare as required by the FEHBP contract;
- \$146,481 for claims of ineligible patients; and,
- \$138,029 for duplicate claim payments.

Of these questioned charges, GEHA agreed with \$1,055,910. In addition, GEHA agreed with the procedural finding regarding the Plan's PPO network pricing oversight, but only partially agreed with the procedural findings relating to the Plan's Fraud and Abuse Program.



Experience-Rated Comprehensive Medical Plans

Comprehensive medical plans fall into one of two categories: community-rated or experience-rated. As we previously explained on page 1 of this report, the key difference between the categories stems from how premium rates are calculated for each.

Members of experience-rated plans have the option of using a designated network of providers or using non-network providers. A member's

choice in selecting one health care provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We did not issue any audit reports on experience-rated comprehensive medical plans during this reporting period.



Information Systems Audits

OPM relies on computer technologies and information systems to administer programs that distribute health and retirement benefits to millions of current and former federal employees. OPM systems also assist in the management of background investigations for federal employees, contractors, and applicants. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal systems could compromise the privacy of the individuals whose information they maintain, as well as the efficiency and effectiveness of the programs that they support.

Our auditors examine the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits. *General controls* refer to the policies and procedures that apply to an entity's overall computing environment. *Application controls* are those directly related to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions. In addition, we are also responsible for performing an independent oversight of OPM's internal information technology and security program. We perform an annual independent audit of OPM's information technology (IT) security environment, as required by the Federal Information Security Management Act of 2002 (FISMA). When necessary, our auditors review system development projects to ensure adherence to best practices and disciplined system development lifecycle processes.

Federal Information Security Management Act Audit FY 2011

WASHINGTON, D.C.

Report No. 4A-CI-00-11-009

NOVEMBER 9, 2011

The Federal Information Security Management Act of 2002 (FISMA) is designed to ensure that the information systems and data supporting Federal operations are adequately protected. FISMA emphasizes the importance of implementing security planning for information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's Inspector General.

Consequently, we audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's (OMB) fiscal year (FY) 2011 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management. Our audit showed that the agency continues to struggle with improving the quality of its information security program.

Audit Activities



Since FY 2007, we have reported a material weakness in the agency's information security program. The policies and procedures were outdated and incomplete with inadequate resources to manage an effective security program. While the agency has made recent progress in updating its IT security and privacy policies, they have not been fully adopted. In our opinion, the fundamental design of the program is flawed.

OPM chose to implement a decentralized model in which designated security officers (DSO) of major systems are appointed by and report to the program offices that own the systems. Very few of the DSOs have any background in information security, and most are only managing their security responsibilities as a secondary duty to their primary job function. The OCIO provides guidance and training to the DSO community, but the effectiveness of this arrangement is limited. Most DSOs do not have the skills necessary to effectively manage system security, and the OCIO has no authority to enforce security requirements.

Given this environment, our audit revealed multiple instances of non-compliance with FISMA requirements, particularly with respect to required annual system controls and contingency plan testing.

IT security is a shared responsibility between the OCIO and program offices. The OCIO is responsible for overall information security governance while program offices are responsible for the security of the systems that they own. There is a balance that must be maintained between a consolidated and a distributed approach to managing IT security, but it is our opinion that OPM's approach is too decentralized. OPM program offices should continue to be responsible for maintaining security of the systems that they own, but the DSO responsibility for documenting, testing, and monitoring system security should be centralized within the OCIO.

Information System General and Application Controls at BlueCross BlueShield of South Carolina

COLUMBIA, SOUTH CAROLINA

Report No. 1A-10-24-11-014

NOVEMBER 9, 2011

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for BlueCross BlueShield of South Carolina (BCBSSC), as well as the various processes and IT systems used to support these applications. We audited controls in place and noted opportunities for improvement in each of the areas below.

Security Management

BCBSSC has established a comprehensive series of IT policies and procedures, a thorough risk management methodology, and adequate security-related human resources policies.

Access Controls

We found that BCBSSC has implemented numerous effective controls to prevent unauthorized access to its facilities and information systems. However, controls in the following areas need improvement:

- Segregation of duties;
- Logical access privileges approval and review;
- Vulnerability scanning and remediation;
- Email encryption;
- Laptop encryption; and,
- Network port scanning.

Configuration Management

BCBSSC has developed formal policies and procedures to ensure that system software is appropriately configured and updated, as well as for controlling system software configuration changes.



Contingency Planning

We reviewed BCBSSC's business continuity plans and concluded that they contained the key elements suggested by relevant guidance and publications. We also determined that these documents are reviewed, updated, and tested on a periodic basis. However, in the event of a disaster, BCBSSC's data backup tapes are stored at a location too close to the data center where they could be potentially impacted by the same disruption.

Application Controls

We noted that BCBSSC has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. We further recommended that BCBSSC implement several system modifications to ensure that its claims processing systems adjudicate FEHBP claims in a manner consistent with the OPM contract and other regulations.

Health Insurance Portability and Accountability Act (HIPAA)

Nothing came to our attention that caused us to believe that BCBSSC is not in compliance with the HIPAA security, privacy, and national provider identifier regulations.

BlueCross BlueShield Association's Federal Employee Program Portability System

COLUMBIA, SOUTH CAROLINA
WILMINGTON, DELAWARE

Report No. 1A-10-00-12-022

FEBRUARY 2, 2012

The BlueCross BlueShield Association (BCBSA) is responsible for adjudicating health benefit claims for Federal employees who participate in the FEHBP's BlueCross BlueShield plan (FEP). The BCBSA has contracted with CareFirst BlueCross BlueShield to host and maintain the FEP Express application and other supporting information systems used to process these claims. Claims processing is initiated by member BCBS plans' claims processing systems.

The Portability project was initiated to create an alternate processing site for FEP claims should CareFirst become unable to fulfill its contract due to the company losing its BCBS license or going out of business altogether (referred to as a "triggering event"). There were also concerns that FEP Express was so tightly interconnected to CareFirst's local claims processing system that the BCBSA would be unable to extract FEP Express functionality if necessary.

The BCBSA also awarded a contract to BlueCross BlueShield of South Carolina (BCBSSC) to provide an alternate processing site for the FEP systems should a triggering event occur. BCBSSC built a technical infrastructure independent from its local systems to support the FEP systems, and worked with CareFirst to extract the applications' functionality.

We reviewed the infrastructure supporting the Portability system and participated in a recent Portability test to perform an independent evaluation of the system's functionality. Our review of the BCBSSC data center hosting the Portability system determined that adequate physical and environmental controls were in place and that the technical infrastructure supporting Portability is physically and logically separate from BCBSSC's own business operations.

To test the system's functionality, we submitted an identical set of test claims into both the CareFirst environment and the BCBSSC Portability environment. Our review showed that the BCBSSC and CareFirst systems processed claims in an identical manner. However, it came to our attention that prior BCBSA Portability tests did not include the following elements that would be critical to a real-life switchover of the FEP systems from CareFirst to BCBSSC:

- sending a response file from the FEP Express system back to the local BCBS plans for final claim adjudication; and,
- enabling the modules of the system that are used by local BCBS plans to resolve claims that are suspended within FEP Express.



We recommended that the BCBSA include these elements in future Portability tests.

Insecure Password Reset Process on OPM-owned Information Systems

WASHINGTON, D.C.

Report No. 4A-RI-00-12-034

FEBRUARY 7, 2012

Employee Express (EEX) is a system operated by OPM on behalf of over 50 Federal agencies. The system allows Federal employees to view and control payroll and personnel information such as tax withholdings, health coverage, financial allotments, Thrift Savings Plan contributions, and earnings and leave statements. The nature of these transactions requires the storage of sensitive personally identifiable information (PII) related to its users. Two other OPM systems, the Employee Benefit Information System (EBIS) and the Electronic Official Personnel Folder (eOPF), also contain large amounts of PII.

In October 2011, OPM's situation room received a tip about a potential security flaw in EBIS related to the way user accounts are created and passwords are reset. Both transactions could be performed by an attacker with basic information easily obtainable through social media or other public information sites on the Internet.

In December 2011, the EEX system was breached by a malicious attack exploiting the website's password reset feature. The attacker had to enter the user's Social Security Number (SSN) and answer three security questions to reset the user's password directly on the EEX web interface. The attacker compromised six different user accounts and accessed these users' PII.

At least one other OPM system, eOPF, has a potentially exploitable password reset function similar to EEX and EBIS. The password reset feature of all three systems could be improved by restricting users' ability to reset passwords directly

on the system's public-facing website. A more secure option would involve a system generated e-mail to the user's Government e-mail address containing a temporary password or a hyperlink to a secure password reset website.

We recommended that the OCIO review the security of the password reset feature of all OPM systems that contain PII. During this review we also determined that the password complexity requirements for EBIS are not compliant with OPM policy, and recommended that the appropriate system modifications be implemented.

Breach of Personally Identifiable Information in Retirement Services

WASHINGTON, D.C.

Report No. 4A-RI-00-12-033

MARCH 13, 2012

We conducted a review of a release of PII that occurred when a contractor for OPM's Retirement Services (RS) program office mailed postcards related to FEHBP open season enrollment to Federal Government annuitants.

Our review indicated that several missing or bypassed information technology security controls resulted in postcards containing exposed PII, including Social Security Numbers (SSN), being printed and mailed through the U.S. Postal Service. In addition, several individuals across multiple OPM organizations did not follow the appropriate procedures for reporting the breach to OPM's Situation Room.

As a result, we recommended that the OCIO strengthen its change management procedures and conduct agency-wide training and awareness campaigns related to incident response and reporting. We also recommended that RS implement a data reconciliation process with its contractor and expand its offer of free credit monitoring services to every individual whose SSN was printed and mailed.



Information Systems General and Application Controls at Medco Health Solutions, Inc.

FRANKLIN PARK, NEW JERSEY

Report No. 1A-10-00-11-052

MARCH 14, 2012

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for Medco, as well as the various processes and IT systems used to support these applications. We documented controls in place and opportunities for improvement in each of the areas below.

Security Management

Medco has established a comprehensive series of IT policies and procedures to promote greater awareness of IT security. We also verified that Medco has adequate human resource policies related to the security aspects of hiring, training, transferring, and terminating employees.

Access Controls

We found that Medco has implemented numerous physical controls to prevent unauthorized access to its facilities, as well as logical controls to prevent unauthorized access to its information systems. However, we found that Medco's data center does not require two-factor authentication for access and that there is no documented review of system administrator activity.

Configuration Management

Medco has developed formal policies and procedures providing guidance to ensure that system software is appropriately configured and updated, controlling system software configuration changes, and monitoring configuration through vulnerability scanning.

Contingency Planning

We reviewed Medco's business continuity plans and concluded that they contained the key elements suggested by relevant guidance and publications. We also determined that these documents are reviewed, updated, and tested on a periodic basis.

Claims Adjudication

Medco has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we found that Medco does not use the OPM debarred provider listing to update its master pharmacy database. We also recommended that Medco implement several system modifications to ensure that its claims processing systems adjudicate FEHBP claims in a manner consistent with OPM contracts and other regulations.

Health Insurance Portability and Accountability Act

Nothing came to our attention that caused us to believe that Medco is not in compliance with the HIPAA security and privacy regulations.



Internal Audits

OPM Internal Performance Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM’s operations and their corresponding internal controls. One critical area of this activity is the audit of OPM’s consolidated financial statements required under the Chief Financial Officers (CFO) Act of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

OPM’s Fiscal Year 2011 Improper Payments Reporting

WASHINGTON, D.C.

Report No. 4A-RI-00-12-009

MARCH 14, 2012

We conducted a performance audit of the Office of Personnel Management’s (OPM) Fiscal Year 2011 Improper Payments Reporting for compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA). This audit was conducted pursuant to IPERA guidance issued by the Office of Management and Budget (OMB) requiring agency Inspectors General to review their agency’s improper payments reporting in the Agency Financial Report (AFR) for compliance with IPERA. The criteria for compliance with IPERA are the following:

- Published an AFR for the most recent fiscal year and posted that report and any accompanying materials required by OMB on the agency website;
- Conducted program specific risk assessments of all programs and activities to identify those that are susceptible to significant improper payments;

- Published improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment in the AFR;
- Published programmatic corrective action plans in the AFR;
- Published, and has met, annual reduction targets for each program assessed to be at risk for improper payments;
- Reported a gross improper payment rate of less than 10 percent for each program or activity for which an improper payment estimate was obtained and published in the AFR; and,
- Reported information on its efforts to recapture improper payments.

OPM not in Compliance with Two of Seven IPERA Reporting Requirements

The objective of our audit was to determine if OPM’s improper payments reporting in the AFR was compliant with IPERA requirements. We determined that OPM was not in compliance with two of the seven IPERA reporting requirements



because it did not include a discussion in its AFR on accountability for reducing and recovering improper payments, and did not discuss its efforts under its recapture audit program. In addition, we identified the following control weaknesses over improper payments reporting in the AFR:

- OPM does not have an updated plan for preventing, reducing, recapturing, and reporting on improper payments under IPERA requirements.
- OPM does not have policies and procedures at the program level for the collection, documentation, and review of reportable data for improper payments reporting.
- OPM did not address specific corrective actions to correct specific root causes of improper payments in the AFR.

We recommended that OPM establish controls to ensure it meets IPERA reporting requirements and improve its controls over the improper payments reporting process.

OPM's Interagency Agreement Process

WASHINGTON, D.C.

Report No. 4A-CF-00-09-014

MARCH 28, 2012

We conducted a performance audit of OPM's Interagency Agreement (IA) Process. Our main objective was to determine if OPM's IAs are being

properly executed, monitored, and managed. Specifically, we performed tests to determine if OPM:

- has controls in place to ensure IAs meet the requirements of applicable laws, regulations, procedures, and guidance, and,
- properly manages the financial aspects of its IAs.

An interagency agreement is a written agreement between Federal agencies in which one agency provides goods or services to another agency on a reimbursable basis. In addition, there are agreements that exist between OPM entities, which are called intra-agency agreements. Both types of IAs establish the general terms and conditions that govern the relationship between the requesting (buyer) and servicing (seller) agencies. The IA provides information that is required to demonstrate a bona fide need and authorizes the transfer and obligation of funds.

We determined that OPM needs to strengthen controls over IAs regarding the financial aspects of preparing and approving agreements to ensure that they are being properly executed, monitored, and managed, when OPM is either the buyer or seller. OPM also needs to provide adequate controls over its record keeping ensuring that reliable documentation is preserved. Lastly, the Chief Financial Officer needs to strengthen its current policies and procedures for purchasing goods and services between Government agencies.



Special Audits

In addition to health and life insurance, OPM administers various other benefit programs for Federal employees which include the: Federal Employees' Group Life Insurance (FEGLI) program; Federal Flexible Spending Account (FSAFEDS) program; Federal Long Term Care Insurance Program (FLTCIP); and, Federal Employees Dental and Vision Insurance Program (FEDVIP). Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers are in accordance with the contracts and applicable Federal regulations. Additionally, our staff performs audits of the Combined Federal Campaign (CFC) to ensure that monies donated by Federal employees are properly handled and disbursed to charities according to the wishes of the employees.

Federal Long Term Care Insurance Program

The FLTCIP was established by the Long Term Care Security Act of 2000, which directed OPM to develop and administer a long term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

In December 2001, OPM awarded a seven year contract to the Long Term Care Partners (LTCP) to offer long term care insurance coverage to eligible participants. Originally, the LTCP was a joint venture between the John Hancock Life Insurance Company (John Hancock) and the Metropolitan

Life Insurance Company. The contract began in March 2002, and expired in April 2009. A new contract was awarded to John Hancock upon the expiration of the original contract. The LTCP, with OPM oversight, is responsible for all administrative functions of the program, including marketing and enrollment, underwriting, policy insurance, premium billing and collection, and claims administration.

In March 2005, OPM amended the LTCP contract to include the development, maintenance and administration of a voluntary benefits portal to support the provisions of the FLTCIP, FEDVIP, and the FSAFEDS program.



Federal Long Term Care Insurance Program Operations

PORTSMOUTH, NEW HAMPSHIRE

Report No. 1G-LT-00-10-022

NOVEMBER 10, 2011

This audit covered claim benefit payments, administrative expenses, cash management activities, and the Contract's requirements related to the prevention of fraud and abuse and the Health Insurance Portability and Accountability Act for the period August 2008 through September 2009. For fiscal year 2009, LTCP received \$298 million in premium revenue and incurred \$31 million and \$17.9 million in claim and administrative expenses, respectively.

Our auditors identified \$861,275 in program overcharges, including \$53,593 in lost investment income. Our most significant findings are that LTCP charged the Program:

- \$796,021 for program maintenance costs that were either not properly supported or not directly related to the Carriers' role of financial and legal oversight of the Program; and,
- \$11,611 for unallowable travel-related and administrative expenses.

The LTCP agreed to all questioned amounts and has already addressed these identified issues.

Federal Employees' Dental and Vision Insurance Program

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 established a dental and vision benefits program for Federal employees, annuitants, and their eligible family members. OPM awarded ten carriers with seven year contracts to provide dental and vision insurance services for the FEDVIP.

Federal Employees Dental and Vision Insurance Program Operations as Administered by the Office of Personnel Management

WASHINGTON, D.C.

Report No. 1J-oL-00-11-033

FEBRUARY 1, 2012

In its role as an administrator of FEDVIP, OPM is responsible for: 1) maintaining the FEDVIP website; 2) acting as a liaison with Federal agencies; 3) facilitating the promotion of the FEDVIP through Federal agencies; 4) responding on a timely basis to the Carrier's requests for information and assistance, and; 5) performing functions typically associated with insurance commissions such as the review and approval of rates, forms, and education materials.

Our auditors reviewed OPM's administration and oversight of the FEDVIP, including operational activities, cash management, and fraud and abuse policies and procedures for 2006 through 2009. While the FEDVIP is operated on a contract year basis, OPM charged expenses against the FEDVIP on a fiscal year basis.

We identified four findings and two areas for program improvement. Specifically, we found:

- \$2.4 million in FEDVIP administrative expenses which were not actual, allocable, or reasonable costs. Due to a lack of internal controls, it was difficult for OPM to determine from whom the overcharges should be recouped. We recommended the implementation of stronger controls to ensure that future charges against FEDVIP funds are for actual FEDVIP costs;
- inadequate support for salary expenses totaling \$568,699 that were charged to the FEDVIP in 2007;
- lack of yearly reconciliations of the budgeted to actual expenses for fiscal years 2006 through 2009 as required by the Contract;



- unsupported documentation of the method used to establish funding to administer the FEDVIP, resulting in an excess of \$8.4 million in unspent FEDVIP funds after fiscal year 2009;
- deficient enforcement of OPM's contract requirement for the FEDVIP Carriers to provide annual accounting statements; and,
- inadequate internal controls for the approval and review of administrative expenses. Additionally, it also does not have policies and procedures in place to prevent fraud and abuse in relation to the funds it receives for its administration of the FEDVIP.

OPM agreed with our audit recommendations and has already implemented corrective actions to close one of the recommendations. It is also in the process of developing corrective actions to address the remaining open recommendations, including lowering its 2012 administrative fee and buying down the 2012 premiums in order to reduce the amount of unspent FEDVIP funds.

Combined Federal Campaign

The Combined Federal Campaign (CFC) is the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM has the responsibility, through both law and executive order, to regulate and oversee the conduct of fundraising activities in Federal civilian and military workplaces worldwide.

CFCs are identified by geographical areas that may include only a single city, or encompass several cities or counties. Our auditors review the administration of local campaigns to ensure compliance with Federal regulations and OPM guidelines. In addition, all campaigns are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. The audit must be in the form of an agreed-upon procedures engagement to be completed by an IPA. We review the IPA's work as part of our audits.

CFC audits do not identify savings to the government, because the funds involved are charitable donations made by Federal employees. Our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's Office of the Combined Federal Campaign (OCFC) works with the auditee to resolve the findings after the final audit report is issued.

LOCAL CFC AUDITS

The local organizational structure consists of:

- **Local Federal Coordinating Committee (LFCC)**
The LFCC is a group of Federal officials designated by the Director of OPM to conduct the CFC in a particular community. It organizes the local CFC; determines the eligibility of local charities; selects and supervises the activities of the Principal Combined Fund Organization (PCFO); encourages Federal agencies to appoint employees to act as Loaned Executives who work directly on the local campaign; ensures that Federal employees are not coerced to participate in the local campaign; and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.
- **Principal Combined Fund Organization**
The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. The primary goal of the PCFO is to administer an effective and efficient campaign in a fair and even-handed manner aimed at collecting the greatest amount of charitable contributions possible. Its responsibilities include collecting and distributing CFC funds, training volunteers, maintaining a detailed accounting of CFC administrative expenses incurred during the campaign, preparing pledge forms and charity lists, and submitting to and cooperating fully with audits of its operations. The PCFO is reimbursed for its administrative expenses from CFC funds.



■ **Federations**

A federation is a group of voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.

■ **Independent Organizations**

Independent Organizations are organizations that are not members of a federation for the purposes of the CFC.

During this reporting period, we issued four audit reports of local CFCs and one audit report of a CFC's Local Federation. Due to the numerous audit findings and the nature of issues we identified in one audit, we recommended that the Capital Region CFC be merged with another campaign that could more effectively handle the responsibilities of the CFC. Another audited CFC, the Greater Rochester CFC, had already been merged into another campaign by the time the final report was issued.

We also recommended that the OCFC consider sanctions against the PCFO of the California Gold Coast CFC to include barring its participation in the CFC because of the difficulties encountered during the performance of our audit, the numerous audit issues identified, and their lack of cooperation.

Of serious concern is the continued identification of similar findings from audit to audit. The causes of these findings can be attributed to the following program concerns:

- The PCFO was either not aware of, or did not understand its responsibilities as defined in the program regulations and CFC Memoranda, or simply did not follow said regulations and Memoranda.
- The LFCC was either not aware of or did not understand its responsibilities as defined in the program regulations.
- The LFCC is inactive and does not perform the needed oversight of the PCFO.

- The IPAs hired to perform the agreed-upon procedures audit, which is paid for out of campaign funds, do not understand the requirements of the audit, which results in findings not being identified and communicated to the PCFOs and LFCCs.

Our audit of the CFC of the National Capital Area revealed the following deficiencies:

■ **PCFO Overcharged for Travel Expenses**

The PCFO was reimbursed \$40,081 for unreasonable, unallowable, or unsupported expenses it categorized as travel expenses for the 2007 through 2009 campaigns. Included in these costs were expenses for meals provided during routine CFC business activities, a Loaned Executive Christmas party, and chair massages. Additionally, the PCFO also charged expenses of \$15,803 to the wrong campaigns. However, we did not require that these amounts be reallocated to the appropriate campaigns, since the 2007 through 2009 campaigns were already closed as of the date of the final report.

■ **PCFO Overcharged for Campaign Expenses**

The PCFO was reimbursed \$268,739 for unreasonable, unallowable, or unsupported expenses for the 2007 through 2009 campaigns. Included in these costs were expenses for meals provided during routine CFC business activities; a Loaned Executive tour of Washington; group tickets for a Washington Nationals baseball event, private box seating, and a mascot visit; jazz band entertainment at a CFC leadership conference; and chair massages. Additionally, the PCFO also charged expenses of \$111,047 to the wrong campaigns. We also identified \$764,069 related to training events, CFCNCA conferences, design and marketing services, software applications and licensing fees, appreciation luncheons, and finale events that could have been put to better use by the PCFO.



■ ***Improper Accounting for Campaign Expenses by PCFO***

The PCFO's accounting policies and procedures allowed for the reimbursement of accrued costs as well as actual costs, which could potentially result in overcharges to the campaign and limit the amounts disbursed to the participating charities.

■ ***PCFO was Reimbursed for Estimated Expenses***

The PCFO was incorrectly reimbursed \$2,129 for estimated expenses related to a special distribution of funds.

■ ***Unearned Interest in the CFCNCA Bank Accounts***

The PCFO did not obtain approval from the OCFC for earning a credit, instead of interest, on campaign funds in one of its CFC bank accounts.

■ ***Untimely Notice of Eligibility Decisions by LFCC***

The LFCC did not issue its eligibility decisions within 15 business days of the closing date for

receipt of applications, for charities wishing to participate in the 2008 campaign.

■ ***Untimely PCFO Reimbursement for 2007 and 2008 Expenses***

The PCFO reimbursed itself for CFC campaign expenses after the date set by OPM's OCFC for final campaign disbursements for the 2007 and 2008 campaigns.

We provided audit findings and recommendations for corrective action to OPM management. OPM notified the CFCNCA's PCFO of our recommendations and is monitoring any corrective actions. If the CFCNCA's PCFO does not comply with the recommendations, the Director of OPM can deny the organization's future participation in the CFC. As a result of this particular audit, the Director of OPM issued a directive to PCFOs and LFCCs of all campaigns disallowing the reimbursement of meals and entertainment events using campaign funds, effective March 28, 2012.



Enforcement Activities

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$920 billion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over eight million current and retired Federal civilian employees, including eligible family members, and disburse over \$100 billion annually. The majority of our OIG criminal investigative efforts are spent examining potential fraud against these trust funds. However, we also investigate OPM employee misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our office opened 24 criminal investigations and closed 40, with 125 still in progress. Our criminal investigations led to 24 arrests, 32 indictments and informations, 22 convictions and \$3,563,333 in monetary recoveries to OPM administered trust funds. Our criminal investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$85,086,059 in criminal fines and penalties which are returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a complete statistical summary of our office's investigative activity, refer to the table on page 31.



Health Care Fraud

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP. Of particular concern are the growth of medical identity theft and organized crime in health care fraud, which has affected the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other Federal, state, and local law enforcement agencies. We are participating members of health care fraud task forces across the nation. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.

Our special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and enrollees. Additionally, special agents work closely with our auditors when fraud issues arise during carrier audits. They also coordinate with the OIG's debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions. The following investigative cases represent some of our activity during the reporting period.

Health Care Fraud Cases

Telemedicine Company Agrees to \$18.5 Million Settlement

In March 2012, LifeWatch Services, Inc. (LifeWatch), a company providing wireless remote telemedicine services, agreed to pay the Government \$18.5 million to settle allegations of improper billings between January 2007 and October 2011 to Federal health care plans. LifeWatch, is a subsidiary of LifeWatch AG, a Swiss company.

This case was based on two separate qui tams brought about by two former sales representatives in Ohio and Washington. Both relators alleged that LifeWatch improperly billed for ambulatory cardiac monitoring services using diagnostic codes not supported by medical records. The relators further alleged that LifeWatch provided services not medically necessary because alternative monitoring services, such as traditional Holter monitoring or cardiac event recording, would be a more appropriate choice.

*In accordance with the **qui tam** provisions of the False Claims Act, a private party can file an action on behalf of the United States and receive a portion of the settlement if the Government takes over the case and reaches a monetary agreement with the defendant(s).*

As a result of the settlement the FEHBP is expected to receive \$389,219.

This was a joint investigation by the Department of Health and Human Services (HHS) OIG, Defense Criminal Investigative Service (DCIS), and our office.

Federal Employee Sold Narcotics Obtained from the FEHBP

A National Institutes of Health (NIH) employee was convicted of selling narcotic prescription medications obtained from the FEHBP.

The FBI requested assistance from OPM OIG investigators and set up an undercover operation in which the employee sold narcotics to undercover agents on two separate occasions. The drugs sold to Federal agents included Methadone, Dilaudid, and Roxicet, a generic equivalent of Oxycodone. In addition the employee confessed to selling narcotics to a co-worker. In July 2011, he pled guilty to criminal information charges of one count of distribution of Roxicet, a schedule II controlled dangerous substance.



The employee acquired the narcotics as a result of an injury sustained from an accident with a drunk driver. Following the injury, he took advantage of a long standing professional relationship with a registered nurse practitioner at a pain management clinic. He exaggerated his pain symptoms to receive extra pills for an existing narcotic prescription and was reimbursed through the FEHBP.

In November 2011, the employee was sentenced to 24 months of probation, a \$1,000 fine and a special assessment of \$100.

The investigation was conducted jointly with the FBI and our office.

Las Vegas Physician Submits False Claims

In December 2011, a physician agreed to pay over \$1 million to settle allegations of submitting false medical claims. This physician owned and operated a pain management center.

This case originated in the United States Attorney's Office following an audit by the Tricare program. The subsequent investigation determined that the physician submitted false medical claims to various Federal health programs including the FEHBP between July 2007 and December 2010.

The physician's improper billings included:

- Charging for physical therapy services performed by a massage therapist under the physician's provider number;
- Billing for physician assistant services under his provider number; and
- Charging for questionable and unnecessary drug screening.

The FEHBP program recovered \$58,294 from the total settlement.

This was a joint investigation with Department of Health and Human Services (HHS) OIG, Department of Defense (DoD) OIG, and OPM OIG.

Retirement Fraud

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). Retirement fraud involves the intentional receipt and use of CSRS or FERS annuity benefit payments by an unentitled recipient.

Our Office of Investigations uses a variety of approaches to identify potential cases for investigation. We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. Routinely, OPM's Retirement Services office refers potential fraud cases, identified through computer death matches with the Social Security Administration (SSA), to our office. We also coordinate with the Department of the Treasury's Financial Management Service to obtain payment information. Other referrals come from Federal, state, and local agencies, as well as private citizens.

Retirement Fraud Cases

Son Conceals Father's Death and Collects Over \$1.2 Million in Annuity Payments

A September 2009 death match conducted with the SSA revealed that a retired Federal annuitant died in March 1983. Since OPM was never notified of the death, the annuity payments continued, resulting in an overpayment of over \$1.2 million.

Our investigation determined that the son, who was appointed guardian, signed four address verification letters, falsely certifying that his father was still alive. All four forms indicated that the annuitant was alive and had Alzheimer's disease.



During an interview with our investigators, the son admitted that he had control over his father's finances as his guardian. He confessed that he withdrew the annuity funds from his father's account by writing a check and depositing the funds into his own bank account. He monitored his father's account by viewing the statements to determine how much money to withdraw.

In October 2011, the son pled guilty to theft of public money. He agreed to forfeit all proceeds traceable to the theft, including a seven-acre farm, a 2005 Ford F350 pickup truck, and \$4,000 in cash to the United States. In March 2012, the son was sentenced to 44 months in prison to be followed by three years of supervised release. Additionally, he was ordered to pay restitution in the amount of over \$1.2 million to OPM.

This was a joint investigation conducted by the United States Secret Service (USSS) and the OPM OIG resulting in the largest court ordered restitution of an OPM retirement annuity investigation.

Deceased Annuitant's Step-Daughter Steals Federal Benefits from OPM, DoD, and SSA

This case was initiated by an SSA OIG project verifying the vital status of their actively paid recipients over 100 years old. SSA OIG requested the assistance of OPM OIG in determining the whereabouts of an annuitant believed to be over 103 years old. The joint investigation determined that this annuitant died in August 1984 and his step-daughter withdrew money from her step-father's bank account containing funds from OPM, SSA and DoD.

SSA OIG agents interviewed the daughter who stated that her step-father disappeared sometime in August 1984 near Las Vegas, Nevada, while traveling in his car to visit her. She filed a missing persons police report, and stated she had not seen her step-father since. As part of her plea agreement she agreed to take a polygraph examination. The results vindicated that she was

in no way responsible for the disappearance of her step-father. However, she admitted to using her step-father's funds to pay her personal expenses.

In October 2011, the step-daughter was sentenced to 18 months in prison and three years supervised release. In addition, she was ordered to pay \$848,435 in restitution to the SSA, the DoD, and the OPM, of which OPM's portion is \$302,632.

Daughter Ordered to Repay Over \$151,700 in Stolen Annuity Payments

Through a computer match conducted between OPM's active annuity rolls and the SSA's death records, OPM determined that a Federal survivor annuitant died in 1992. However, benefits continued to be paid after her death resulting in an over-payment of \$151,722 over a course of 14 years.

Our investigation determined that the survivor annuitant's daughter forged her mother's name on the annuity checks and deposited the payments in her personal bank account. The daughter confessed to signing her mother's name on her mother's checks, but maintained that after her mother's death, she did not know that this practice was disallowed.

In July 2011, the daughter pled guilty to theft of public money. In October 2011, the daughter was sentenced to five years probation and ordered to pay full restitution in the amount of \$151,722 to OPM.

This was a joint investigation by the USSS and the OPM OIG.

Elderly Brother Steals Deceased Brother's Annuity Payments

OPM determined that a Federal survivor annuitant died in November 2000, through a computer match conducted between OPM's active annuity



rolls and the SSA's death records. Since OPM was never notified of the annuitant's death, the annuity payments continued resulting in an overpayment of \$144,975.

The investigation revealed that the survivor annuitant's brother forged his brother's signature on three address verification letters, falsely certifying that his brother was still alive. During an interview with the 81 year old brother, he confessed to signing the address verification letters and mailing them to OPM. He also admitted to using the annuity money because he felt entitled to it and needed money.

In November 2011, the brother pled guilty to Grand Larceny. This case was prosecuted by the local District Attorney in New Rochelle, New York after having been declined at the Federal Circuit. In February, 2011 he was sentenced to five years probation and ordered to pay full restitution in the amount of \$144,975 to OPM.

This was a joint investigation by the USSS and the OPM OIG.

Nephew and His Father Steal Over \$275,000 in Annuity Payments

Through a computer match conducted between OPM's active annuity rolls and SSA's death records, OPM determined that a Federal annuitant died in January 2007. Because OPM was never notified of the annuitant's death, the annuity payments continued, resulting in an overpayment of \$275,219.

Our investigation determined that the annuity payments were initially deposited to an account controlled by the nephew's father. During this time the father submitted income tax returns for the deceased annuitant. Upon the father's death, the nephew continued the scheme by receiving annuity payments, transferring the money from his father's account to his personal account, and filing false tax returns for his aunt. Additionally, he

forged two Address Verification Letters sent by the OPM to the annuitant. Both letters were returned indicating that the annuitant was still alive and bearing the alleged signature of the annuitant.

In November 2011, the nephew was sentenced to three years probation, four months home confinement and ordered to pay \$118,599 in restitution to OPM. It was determined that the remaining overpayment was attributable to his deceased father and unrecoverable.

Daughter Steals VA Benefits and OPM Annuity

This case was initiated by the Veterans Administration (VA) after the subject admitted not reporting her mother's death to the VA and the OPM so that she could continue receiving her mother's survivor annuity payments. The VA requested our assistance after determining that OPM annuity payments were involved.

The daughter received \$56,630 in improper benefits from OPM, following her mother's death. In addition, the daughter also continued receiving VA benefits totaling \$68,260 intended for her mother.

The daughter confessed to not reporting her mother's death to OPM and the VA so that she could continue to receive the benefits. She also admitted forging her mother's signature on personal checks to access the money deposited into a bank account that was solely held by her mother.

The daughter pled guilty to two counts of theft of public money. In September 2011, she was sentenced to five months of incarceration, five months of home detention, three years probation, and ordered to pay restitution in the amount of \$124,890 with OPM receiving \$56,630 and the VA receiving \$68,260.

This was a joint investigation by the VA OIG and the OPM OIG.



Representative Payee Conceals Mother's Death

A death computer match with SSA revealed that a Federal survivor annuitant died in 2004. The OPM was never notified; therefore the annuity payments continued and resulted in an overpayment of \$71,989.

Our investigators determined that the daughter was a representative payee for her mother's survivor annuity prior to her mother's death. A representative payee is established when OPM determines that an annuitant is unable to handle their financial affairs.

The investigation revealed that the daughter forged her mother's signature on three address verification letters, falsely certifying that her mother was alive. The mother died May 2004. In October 2009, an OPM representative telephonically spoke with the daughter who falsely stated that her mother was still alive, continuing the annuity payments.

In November 2011, the daughter pled guilty to theft of public money. In February 2012, the daughter was sentenced to three years probation and ordered to pay full restitution to OPM in the amount of \$71,989.

This was a joint investigation by the USSS and OPM OIG.

Revolving Fund Program Investigations

Our office investigates OPM employee misconduct and other wrongdoing, including allegations of fraud within OPM's revolving funds programs, such as the background investigations and human resources products and services.

OPM's Federal Investigative Services (FIS) conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts approximately 90 percent of all personnel background investigations for the

Federal Government. With a staff of over 9,200 Federal and contract employees, FIS processed over 1 million investigations in FY 2012. Federal agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

The violations investigated by our special agents include fabrication by background investigators (i.e., the submission of work products that purport to represent investigative work which was not in fact performed). We consider such cases to be a serious national security concern. If a background investigation contains incorrect, incomplete, or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities or classified information.

OPM's Human Resources Solutions (HRS) provides other Federal agencies, on a reimbursable basis, with human resource products and services to help agencies develop leaders, attract and build a high quality workforce, and transform into high performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our special agents include employee misconduct, regulatory violations, and contract irregularities.

OPM Contract Background Investigator Falsified Numerous Reports of Background Investigations

The OIG received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements by a former contract OPM background investigator.

Between July 2006 and December 2007, in more than four dozen background investigation reports, we determined that the background investigator falsely represented he had interviewed



a source or reviewed a record regarding a subject. These FIS reports of investigation were used by agencies requesting background investigations to determine whether the subjects were suitable for job positions involving classified information, impacting national security, or receiving security clearances.

These false representations required OPM FIS to reopen and reinvestigate the casework assigned to the background investigator, which cost OPM \$131,102. In July 2011, he pled guilty to a charge of making a false statement. In October 2011, the background investigator was ordered to pay full restitution to OPM FIS and he was sentenced to three years of probation.

OIG Hotlines and Complaint Activity

The OIG's Health Care Fraud Hotline, Retirement and Special Investigations Hotline, online anonymous complaint form, and mailed-in complaints also contribute to identifying fraud and abuse. We received 581 hotline inquiries during the reporting period. The table on page 31 reports the summary of hotline activities.

The information we receive on our OIG hotlines generally concerns FEHBP health care fraud, retirement fraud and other complaints that may warrant special investigations. Our office receives inquiries from the general public, OPM employees, contractors and others interested in reporting waste, fraud and abuse within OPM and the programs it administers.

In addition to hotline callers, we receive information from individuals who report through the mail or have direct contact with our investigators. Those who report information can do so openly, anonymously and confidentially without fear of reprisal.

RETIREMENT FRAUD AND SPECIAL INVESTIGATIONS HOTLINE

The Retirement Fraud and Special Investigations Hotline provides a method for reporting waste, fraud and abuse within the agency and its

programs. During this reporting period, this hotline received a total of 277 contacts, including telephone calls, emails, letters, and referrals from other agencies.

HEALTH CARE FRAUD HOTLINE

The Health Care Fraud Hotline receives complaints from subscribers in the FEHBP. The hotline number is listed in the brochures for all the FEHBP health insurance plans, as well as on our OIG Web site at www.opm.gov/oig.

While the hotline was designed to provide an avenue to report fraud committed by subscribers, health care providers or FEHBP carriers, callers frequently request assistance with disputed claims and services disallowed by the FEHBP carriers.

The Health Care Fraud Hotline received 304 complaints during this reporting period, including telephone calls, emails, and letters.

OIG AND EXTERNAL INITIATED COMPLAINTS

Based on our knowledge of OPM program vulnerabilities, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we initiated 48 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 295 health care fraud preliminary inquiry complaints. These efforts may potentially evolve into formal investigations.

We believe that these OIG and external initiated complaints complement our hotline to ensure that our office continues to be effective in its role to guard against and identify instances of fraud, waste and abuse.

CORRECTION OF PRIOR PERIOD SEMIANNUAL REPORT

In our semiannual report for the period ending September 30, 2011, we underreported \$16,640 involving a health care investigation. This investigation resulted in a civil settlement, but notification of the final settlement recovery was delayed.



Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 31,789 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 354 administrative sanctions – including both suspensions and debarments – of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 1,881 sanctions-related inquiries.

We develop our sanctions caseload from a variety of sources, including:

- Administrative actions issued against health care providers by other Federal agencies;
- Cases referred by the OIG's Office of Investigations;
- Cases identified by our office through systematic research and analysis of electronically-available information about health care providers, referred to as e-debarment; and,
- Referrals from other sources, including health insurance carriers and state Government regulatory and law enforcement agencies.

Sanctions serve a protective function for the FEHBP and the Federal employees who obtain, through it, their health insurance coverage.

The following articles, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk, or have obtained fraudulent payment of FEHBP funds.

Debarment *disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. The FEHBP administrative sanctions program establishes 18 bases for debarment. The ones we cite most frequently are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives prior notice and the opportunity to contest the sanction in an administrative proceeding.*

Suspension *has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.*



Ohio Physician and Practices Debarred After Medical License is Revoked

In August 2011, the State Medical Board of Ohio (SMBO) permanently revoked an Ohio physician's medical license based on her criminal convictions. The physician plead guilty to two felony counts of telecommunications fraud, four felony counts of insurance fraud and one felony count of engaging in a pattern of corrupt activity.

Based on notification from our Office of Investigations, we debarred an Ohio physician and her three medical practices in March 2012. Our debarment was based on the SMBO's decision to permanently revoke the physician's medical license for violating certain laws and regulations governing the practice of medicine and surgery in Ohio.

The physician's felony convictions for insurance fraud involved submitting claims for medical services and supplies which were never provided or provided at lower levels of care and quantities than those specified; manipulating coding to disguise claims that would otherwise be ineligible for payment; and creating false statements on insurance application forms and patient progress notes in order to secure insurance coverage and payment.

Through her Ohio practice, the physician began processing fraudulent claims to multiple insurance companies. The Ohio Department of Insurance's investigation of the physician and her Ohio practice revealed that she submitted over \$950,000 in fraudulent claims to several health insurance providers and was paid \$234,144 for fraudulent claims processed by the insurance providers.

The physician was sentenced to 5 years supervised probation; 300 hours of community service; and ordered to pay full restitution to the

health insurance providers. In addition, we found that the physician owns and/or controls two other medical practices located in Pennsylvania and Michigan. Although she was licensed to practice medicine in both states, her Michigan medical license has expired and her Pennsylvania medical license has been revoked. Also, we identified a nexus between the physician, her Ohio and Pennsylvania practices, and at least one of our major FEHBP carriers.

Our debarment of the physician and her medical practices is for an indefinite period pending resolution of the physician's Ohio medical licensure.

California Psychiatrist Debarred for Sexual Misconduct

Based on research and analysis of electronically available information, we debarred a California licensed physician in January 2012. The physician, whose specialty is psychiatry, was cited for unprofessional conduct and violating Federal and state statutes.

Our debarment was based on the Medical Board of California's (MBC) decision in October 2010, ordering the physician to surrender his medical license for violating certain laws and regulations governing the practice of medicine and surgery in California.

The specific offenses in which the physician engaged leading to his debarment included:

- Sexual misconduct: 1) engaging in sexual activity with a female patient that he was treating for depression and sexual trauma, and paying for sex; 2) inappropriately touching a patient during a medical exam; and 3) initiating a year-long sexual relationship with a patient with whom he was providing marital counseling.



Enforcement Activities

- Prescribing medicines that were inappropriate, addictive, and/or contraindicated. One patient later died of liver failure as a result of acetaminophen toxicity.
- Failing to inform patients of the potential side effects of various prescribed narcotics.
- Writing multiple prescriptions for controlled substances to two patients who were addicted to drugs.
- Issuing prescriptions under false names.
- Failing to maintain adequate and accurate records; falsifying and changing information in patient files; and overall negligent care and treatment of patients.

Our debarment of the physician and practice is for an indefinite period pending resolution of his California medical licensure.

North Carolina Physician Assistant Debarred for Loss of Medical License

In January 2012 we debarred a North Carolina physician assistant. Our debarment was based on the North Carolina Medical Board's (NCMB) suspension of the physician assistant's medical license.

The NCMB's suspension of the physician assistant's license was based on violations of North Carolina State law in which the board determined that the physician assistant:

- demonstrated poor overall supervision of cosmetic surgical procedures, including failing to properly document medical examinations acceptable to the medical practice and failing to perform adequate pre-procedure examinations;
- did not demonstrate integrity befitting of a licensed physician assistant; and,
- failed to conform to the standard of acceptable and prevailing medical practice.

Our debarment of the physician assistant is for an indefinite period pending resolution of his North Carolina medical licensure.



Legal Activities

Legislative Proposals

Under the Inspector General Act of 1978, as amended, each statutory Inspector General has the right to obtain his or her own independent legal counsel in order to preserve the independence of the office and avoid possible conflicts of interest in conducting IG audits and investigations. Not only does the Office of Legal Affairs advise the Inspector General and our other offices on legal and regulatory matters, but it also works to develop and promote legislative proposals to prevent and reduce fraud, waste, and abuse in OPM programs.

Between October 2011 and March 2012, Inspector General McFarland testified at two Congressional hearings. Summaries of his testimony are below.

House Committee On Oversight and Government Reform

On November 15, 2011, the Inspector General testified at a hearing entitled, "Back to Basics: Is OPM Meeting Its Mission?" held by the Subcommittee on Federal Workforce, U.S. Postal Service and Labor Policy. In his testimony, the Inspector General addressed OPM's use of information technology (IT) tools to fulfill its core missions, focusing on OPM's role in the hiring and retiring phases of a Federal employee's career.



The Inspector General voiced concerns regarding OPM's IT program and its lack of institutional knowledge regarding the proper processes to follow when developing and implementing an IT system and the decentralized structure of OPM's IT security program.

The agency has struggled with modernizing its retirement IT system and, more recently, with the launch of USAJOBS 3.0. Inspector General McFarland informed Subcommittee members that his office will be conducting two audits of USAJOBS 3.0 this fiscal year. The first will cover IT security with objectives to verify that appropriate IT security controls are in place to minimize the risk of security breaches similar to those that occurred with the prior USAJOBS contractor. The second audit will determine if OPM followed a disciplined systems development process that focused upon investment management, requirements management, testing, project oversight, and risk management.

He concluded the testimony by addressing improper payments to deceased annuitants, the topic of the report that the OIG released in September 2011, "Stopping Improper Payments to Deceased Annuitants."

Health Senate Committee On Homeland Security and Governmental Affairs

On February 1, 2012, Inspector General McFarland testified at a hearing, entitled "Federal Retirement Processing: Ensuring Proper and Timely Payments," held by the Subcommittee on Oversight of Government Management, the Federal Workforce, and the District of Columbia.

The focus of the hearing involved OPM's current retirement processing backlog.

During his testimony, the Inspector General recognized OPM's historical difficulty in developing and implementing IT systems. However, he acknowledged the complexities involved in building an IT system to process retirement claims. For example, there are over 500 procedures, laws, and regulations impacting how retirement annuities are computed. The IT systems that are currently in place to handle retirement claims are very old and have been specifically customized, making the systems very difficult to modify.

The Committee's attention turned to the OPM Strategic Plan that addresses the actions to resolve the backlog in retirement claims. While generally supportive of the plan, the Inspector General did note that he had some questions about various details not presented in the plan. For example, it does not discuss interim milestones that would allow OPM to track its progress towards eliminating the backlog in 18 months. He reported that OIG staff members were in contact with agency personnel to further discuss interim milestones.

Inspector General McFarland concluded his testimony by once again raising his concerns regarding the problem of improper payments OPM makes each year to deceased annuitants. He also reported on the progress that the agency had made since the OIG released its report in September 2011.

The agency has committed to developing a strategic plan to address improper payments, similar to the one regarding the retirement claims backlog.



Statistical Summary of Enforcement Activities

Judicial Actions:

Arrests	24
Indictments and Informations	32
Convictions	22

Judicial Recoveries:

Restitutions and Settlements	\$3,563,333
Fines, Penalties, Assessments, and Forfeitures	\$85,086,059 ¹

Retirement and Special Investigations Hotline and Preliminary Inquiry Complaint Activity:

HOTLINE

Referred to:

OPM Program Offices	181
Other Federal Agencies	87
Informational Only	2
Inquiries Initiated	2
Retained for Further Inquiry	5

Total Received: 277

PRELIMINARY INQUIRY COMPLAINTS

Total Received: 48

Total Closed: 47

Health Care Fraud Hotline and Preliminary Inquiry Complaint Activity:

HOTLINE

Referred to:

OPM Program Offices	33
FEHBP Insurance Carriers or Providers	252
Other Federal Agencies	2
Informational Only	12
Inquiries Initiated	0
Retained for Further Inquiry	5

Total Received: 304

PRELIMINARY INQUIRY COMPLAINTS

Total Received: 295

Total Closed: 285

Hotline Contacts and Preliminary Inquiry Complaints:

Total Hotline Contacts and Preliminary Inquiries Received 924

Total Hotline Contacts and Preliminary Inquiries Closed 903

Administrative Sanctions Activity:

Debarments and Suspensions Issued 354

Health Care Provider Debarment and Suspension Inquiries 1,881

Debarments and Suspensions in Effect at End of Reporting Period 31,789

¹This figure represents criminal fines and criminal penalties returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures and court assessments and/or fees resulting from criminal investigations conducted by our office. Many of these criminal investigations were conducted jointly with other Federal agencies, who share the credit for the fines, penalties, assessments, and forfeitures.



Appendices

Appendix I FINAL REPORTS ISSUED WITH QUESTIONED COSTS FOR INSURANCE PROGRAMS

OCTOBER 1, 2011 TO MARCH 31, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$ 9,737,762
B. Reports issued during the reporting period with findings	15	22,839,109
Subtotals (A+B)	20	32,576,871
C. Reports for which a management decision was made during the reporting period:	13	19,411,453
1. Disallowed costs	N/A	19,487,932
2. Costs not disallowed	N/A	(76,479) ²
D. Reports for which no management decision has been made by the end of the reporting period	7	13,165,418
E. Reports for which no management decision has been made within 6 months of issuance	0	0

²Represents the net of allowed costs, which includes overpayments and underpayments to insurance carriers.



Appendix II – A

FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR ALL OTHER AUDIT ENTITIES

OCTOBER 1, 2011 TO MARCH 31, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	2	\$ 38,712
B. Reports issued during the reporting period with findings	3	474,828
Subtotals (A+B)	5	513,540
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	5	513,540
E. Reports for which no management decision has been made within 6 months of issuance	2	38,712

Appendix II – B

FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS

OCTOBER 1, 2011 TO MARCH 31, 2012

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$120,000,000
B. Reports issued during the reporting period with findings	1	764,069
Subtotals (A+B)	2	120,764,069
C. Reports for which a management decision was made during the reporting period:	1	120,000,000
D. Reports for which no management decision has been made by the end of the reporting period	1	764,069
E. Reports for which no management decision has been made within 6 months of issuance	0	0



Appendix III

INSURANCE AUDIT REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued	Questioned Costs
1C-LB-00-11-024	Health Net of California, Inc. – Northern Region in Woodland Hills, California	October 19, 2011	\$ 0
1A-10-69-11-035	Premera BlueCross in Mountlake Terrace, Washington	October 26, 2011	0
1C-UR-00-11-013	Humana Health Plan of Texas, Inc. in Louisville, Kentucky	November 9, 2011	595,346
1C-F8-00-11-021	Kaiser Foundation Health Plan of Georgia in Atlanta, Georgia	November 9, 2011	0
1G-LT-00-10-022	Long Term Care Partners, LLC in Portsmouth, New Hampshire	November 10, 2011	861,275
1A-10-09-11-018	BlueCross BlueShield of Alabama in Birmingham, Alabama	November 21, 2011	521,891
1A-10-55-11-019	Independence BlueCross in Philadelphia, Pennsylvania	December 1, 2011	167,641
1C-WQ-00-11-057	Aetna Open Access Phoenix and Tucson, Arizona in Blue Bell, Pennsylvania	December 22, 2011	0
1C-LP-00-11-027	Health Net of California – Southern Region in Woodland Hills, California	December 22, 2011	277,265
1A-99-00-11-022	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.	January 11, 2012	6,342,749
1A-10-33-11-023	BlueCross BlueShield of North Carolina in Durham, North Carolina	January 25, 2012	477,872
1J-0L-00-11-033	Federal Employees Dental and Vision Insurance Program as Administered by the Office of Personnel Management in Washington, D.C.	February 1, 2012	0
1C-7D-00-11-065	Aetna Open Access of Cleveland and Toledo, Ohio in Blue Bell, Pennsylvania	February 2, 2012	0
1H-01-00-11-011	BlueCross BlueShield’s Mail Order Pharmacy Operations as Administered by CVS Caremark in 2006 and 2007 in Washington, D.C.	February 2, 2012	325,378
1A-10-24-11-059	BlueCross BlueShield of South Carolina in Columbia, South Carolina	February 7, 2012	0

Appendices



Appendix III

INSURANCE AUDIT REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-E3-00-12-005	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in Rockville, Maryland	February 29, 2012	0
1C-E9-00-12-007	United HealthCare Insurance Company in Hartford, Connecticut	March 1, 2012	0
1A-10-91-11-030	BlueCross BlueShield Association in Washington, D.C. and Chicago, Illinois	March 6, 2012	105,998
1B-31-00-10-038	Government Employees Health Association, Inc. in Lee's Summit, Missouri	March 12, 2012	1,177,068
1C-WD-00-11-031	Dean Health Plan, Inc. in Madison, Wisconsin	March 12, 2012	571,189
1C-RL-00-11-042	Grand Valley Health Plan, Inc. in Grand Rapids, Michigan	March 13, 2012	1,229,824
1C-2X-00-12-008	Aetna Open Access – Los Angeles and San Diego, California in Blue Bell, Pennsylvania	March 28, 2012	0
1C-QA-00-11-062	Independent Health Association in Buffalo, New York	March 28, 2012	0
1A-99-00-11-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	March 28, 2012	8,898,131
1C-5E-00-11-045	Coventry Health Care of Florida in Sunrise, Florida	March 28, 2012	1,139,191
1C-JV-00-11-061	Fallon Community Health Plan in Worcester, Massachusetts	March 28, 2012	148,291
TOTALS			\$22,839,109



Appendix IV

INTERNAL AUDIT REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued
4A-CF-00-11-050	Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, D.C.	November 14, 2011
4A-CF-00-11-051	Office of Personnel Management's Fiscal Year 2011 Special-Purpose Financial Statements in Washington, D.C.	November 15, 2011
4A-RI-00-12-009	Office of Personnel Management's Fiscal Year 2011 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.	March 14, 2012
4A-CF-00-09-014	Office of Personnel Management's Interagency Agreement Process in Washington, D.C.	March 28, 2012

Appendix V

COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued	Questioned Costs
3A-CF-00-11-039	The 2009 Combined Federal Campaign Activities of Community Shares of Mid Ohio in Columbus, Ohio	January 6, 2012	\$ 0
3A-CF-00-11-037	The 2008 through 2010 California Gold Coast Combined Federal Campaigns in Camarillo, California	February 14, 2012	106,123
3A-CF-00-10-034	The 2007 through 2010 Combined Federal Campaigns of the National Capital Area in Alexandria, Virginia	March 14, 2012	308,820
03A-CF-00-11-041	The 2008 and 2009 Greater Rochester Combined Federal Campaigns in Rochester, New York	March 28, 2012	0
3A-CF-00-11-038	The 2008 and 2009 Capital Region Combined Federal Campaign in Albany, New York	March 30, 2012	59,885
TOTALS			\$474,828

Appendices



Appendix VI

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued
1A-10-24-11-014	Information Systems General and Application Controls at BlueCross BlueShield of South Carolina in Columbia, South Carolina	November 9, 2011
4A-CI-00-11-009	Federal Information Security Management Act Fiscal Year 2011 in Washington, D.C.	November 9, 2011
1A-10-00-12-022	BlueCross BlueShield Association's Federal Employee Program Portability System in Washington, D.C.	February 2, 2012
4A-RI-00-12-034	Insecure Password Reset Process on Agency-owned Information Systems in Washington, D.C.	February 7, 2012
4A-RI-00-12-033	Breach of Personally Identifiable Information in Retirement Services in Washington, D.C.	March 13, 2012
1A-10-00-11-052	Information Systems General and Application Controls at Medco Health Solutions, Inc. in Washington, D.C.	March 14, 2012

Appendix VII

EVALUATION REPORTS ISSUED

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued
1K-RS-00-12-023	Human Resources Solutions 2009 Overlay Rate in Washington, D.C.	February 6, 2012



Appendix VIII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

OCTOBER 1, 2011 TO MARCH 31, 2012

Report Number	Subject	Date Issued
4A-CI-00-07-015	The Privacy Program at the Office of Personnel Management, Washington, D.C.; 7 total recommendations; 1 open recommendation	January 25, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at the Office of Personnel Management, Washington, D.C.; 12 total recommendations; 7 open recommendations	April 16, 2007
1C-3U-00-05-085	UnitedHealthcare of Ohio, Inc., in West Chester, Ohio; 2 total recommendations; 2 open recommendations	January 18, 2008
4A-RI-00-05-037	The Office of Personnel Management's Reclamation Process in Washington, D.C.; 10 total recommendations; 1 open recommendation	March 18, 2008
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana; 2 total recommendations; 2 open recommendations	June 12, 2008
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008; 19 total recommendations; 3 open recommendations	September 23, 2008
4A-CF-00-08-025	Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements; 6 total recommendations; 6 open recommendations	November 14, 2008
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 16 total recommendations; 6 open recommendations	March 26, 2009
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	June 23, 2009
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	July 20, 2009
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	October 14, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009; 30 total recommendations; 5 open recommendations	November 5, 2009
4A-CF-00-09-037	Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statement; 5 total recommendations; 5 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System in Washington, D.C.; 8 total recommendations; 7 open recommendations	January 8, 2010

Appendices



Appendix VIII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

OCTOBER 1, 2011 TO MARCH 31, 2012

(Continued)

Report Number	Subject	Date Issued
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2010
1A-99-00-10-009	Global Coordination of Benefits for BlueCross BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	March 31, 2010
1B-45-00-09-062	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 6 total recommendations; 5 open recommendations	April 14, 2010
1A-10-85-09-023	CareFirst BlueCross BlueShield – Maryland; 18 total recommendations; 9 open recommendations	May 21, 2010
1A-10-41-09-063	Information Systems General and Application Controls at BlueCross BlueShield of Florida in Jacksonville, Florida; 5 total recommendations; 2 open recommendations	May 21, 2010
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 4 open recommendations	June 22, 2010
1A-99-00-09-046	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross BlueShield Plans; 5 total recommendations; 1 open recommendation	July 19, 2010
1C-54-00-09-048	Group Health Cooperative in Seattle, Washington; 4 total recommendations; 4 open recommendations	September 8, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System in Washington, D.C.; 15 total recommendations; 1 open recommendation	September 10, 2010
1C-Q1-00-10-026	Lovelace Health Plan in Albuquerque, New Mexico; 2 total recommendations; 2 open recommendations	September 27, 2010
4A-RI-00-10-014	OPM's Court Ordered Benefits Branch in Washington, D.C.; 7 total recommendations; 6 open recommendations	October 14, 2010
4A-CF-00-10-015	OPM's FY 2010 Financial Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 13 open recommendations	November 10, 2010
4A-CF-00-10-047	Information Technology Security Controls for OPM's Annuity Roll System in Washington, D.C.; in 13 total recommendations; 8 open recommendations	November 22, 2010



Appendix VIII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

OCTOBER 1, 2011 TO MARCH 31, 2012

(Continued)

Report Number	Subject	Date Issued
1B-45-00-10-017	Information Systems General and Application Controls at Coventry Health Care in Scottsdale, Arizona; 15 total recommendations; 5 open recommendations	December 14, 2010
1C-J8-00-10-025	JMH Health Plan in Miami, Florida; 2 total recommendations; 2 open recommendations	December 15, 2010
4A-CF-00-10-043	Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 7 open recommendations	March 4, 2011
1K-RS-00-11-034	Payroll Functions Related to FEHBP Enrollment Transactions for Annuitants in Washington, D.C.; 5 total recommendations; 3 open recommendations	March 14, 2011
4A-CF-00-10-023	OPM's Invoice Payment Process in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2011
1A-10-41-10-012	BlueCross BlueShield of Florida in Jacksonville, Florida; 26 total recommendations; 4 open recommendation	May 12, 2011
4A-CI-00-11-016	Information Technology Security Controls OPM's Enterprise Server Infrastructure General Support System in Washington, D.C.; 3 total recommendations; 2 open recommendations	May 16, 2011
1H-01-00-10-057	Information Systems General and Application Controls at CVS Caremark in Washington, D.C.; 7 total recommendations; 4 open recommendations	May 17, 2011
4A-CF-00-11-015	Information Technology Security Controls for OPM's Consolidated Business Information System in Washington, D.C.; 16 total recommendations; 1 open recommendation	June 1, 2011
1A-99-00-10-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	June 8, 2011
1A-10-85-11-029	Information Systems General and Application Controls at BlueCross and BlueShield Operations Center in Washington, D.C.; 2 total recommendations; 1 open recommendation	June 23, 2011
1B-47-00-11-044	Follow-up Review of Information Systems General and Application Controls at American Postal Workers Union in Glen Burnie, Maryland; 6 total recommendations; 6 open recommendations	June 27, 2011
1A-99-00-10-061	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 2 open recommendations	September 8, 2011



Appendix VIII

SUMMARY OF AUDIT REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

OCTOBER 1, 2011 TO MARCH 31, 2012

(Continued)

Report Number	Subject	Date Issued
1H-80-00-10-062	Group Health Incorporated's Pharmacy Operations in New York, New York; 12 total recommendations; 6 open recommendations	September 8, 2011
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 4 open recommendations	September 14, 2011
4A-CI-00-11-043	Information Technology Security Controls OPM's Center for Talent Services General Support Systems in Washington, D.C.; 5 total recommendations; 5 open recommendations	September 28, 2011
1C-ML-00-11-004	AvMed Health Plans in Gainesville, Florida; 2 total recommendations; 2 open recommendations	September 30, 2011
4A-HR-00-11-012	OPM's Human Resource Solutions' Vendor Management Branch in Washington, D.C.; 2 total recommendations; 2 open recommendations	September 30, 2011



APPENDIX IX MOST RECENT PEER REVIEW RESULTS

APRIL 1, 2011 TO SEPTEMBER 30, 2011

Subject	Date of Report	Result
Report on the System Review of the U.S. Department of the Interior Office of the Inspector General Audit Organization <i>(Issued by the Office of Inspector General, U.S. Office of Personnel Management)</i>	July 29, 2011	Pass ³
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Tennessee Valley Authority <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	December 14, 2010	Compliant ⁴
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management <i>(Issued by the Office of Inspector General, U.S. Agency for International Development)</i>	June 2, 2010	Full Compliance ⁴
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization <i>(Issued by the Office of Inspector General, U.S. Agency for International Development)</i>	September 25, 2009	Pass ³

³A peer review of **Pass** is issued when the reviewing Office of Inspector General concludes that the system of quality control for the reviewed Office of Inspector General has been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. There are no deficiencies or significant deficiencies that affect the nature of the Peer Review and, therefore, the Peer Review does not contain any deficiencies or significant deficiencies.

⁴A rating of **Compliant or Full Compliance** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.



APPENDIX X INVESTIGATIVE RECOVERIES

OCTOBER 1, 2011 TO MARCH 31, 2012

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2006 00103	Health Care Fraud	Criminal	\$ 0	\$ 0	\$85,000,125
I 2008 00076	Retirement Fraud	Criminal	200,120	200,120	300
I 2008 00100	Retirement Fraud	Criminal	118,599	118,599	100
I 2008 00103	Health Care Fraud	Criminal	0	3,000,000	50,000
I 2009 00060	Health Care Fraud	Criminal	0	0	100
I 2010 00014	Retirement Fraud	Criminal	280,449	280,449	100
I 2010 00029	Retirement Fraud	Criminal	0	48,000	800
I 2010 00050	Health Care Fraud	Criminal	0	0	28,534
I 2010 00084	Retirement Fraud	Criminal	113,978	113,978	100
I 2010 00095	Retirement Fraud	Civil	87,393	90,096	0
I 2010 00099	Retirement Fraud	Criminal	1,246,362	1,246,362	4,100
I 2010 00111	Retirement Fraud	Criminal	71,989	71,989	100
I 2011 00011	Health Care Fraud	Criminal	0	0	1,100
I 2011 00011	Retirement Fraud	Civil	37,044	38,190	0
I 2011 00021	Retirement Fraud	Criminal	302,632	848,435	100
I 2011 00026	Retirement Fraud	Criminal	56,630	124,890	200
I 2011 00041	Retirement Fraud	Criminal	151,722	151,722	100
I 2011 00053	Employee/Contractor Misconduct	Criminal	131,102	131,102	100
I 2011 00055	Retirement Fraud	Criminal	126,465	126,465	100
I 2011 00056	Retirement Fraud	Criminal	38,488	38,488	0
I 2011 00060	Health Care Fraud	Civil	389,219	18,500,000	0
I 2011 00061	Retirement Fraud	Criminal	144,975	144,975	0
I 2011 00067	Health Care Fraud	Civil	3,504	10,519	0
I 2011 00249	Health Care Fraud	Civil	58,294	1,062,072	0
I-12-00184	Health Care Fraud	Civil	4,368	793,548	0
GRAND TOTAL			\$3,563,333	\$27,139,999	\$85,086,059

⁵Cases that are listed multiple times indicate there were multiple subjects.



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(Inspector General Act of 1978, As Amended)

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