

United States Office of Personnel Management

Semiannual Report to Congress

OFFICE OF THE
INSPECTOR GENERAL



April 1, 2015 – September 30, 2015

OFFICE OF THE INSPECTOR GENERAL



Indicators

Financial Impact:

Audit Recommendations for Recovery of Funds	\$58,301,213
Management Commitments to Recover Funds	\$53,814,438
Recoveries Through Investigative Actions	\$32,592,655

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	33
Special Review Reports Issued	1
Indictments and Informations	13
Arrests	7
Convictions	10
Hotline Contacts and Preliminary Inquiries Complaints	868
Health Care Provider Debarments and Suspensions	479
Health Care Provider Debarment and Suspension Inquiries	2,839

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Message from the Inspector General



"One of our most important responsibilities is to Federal employees, their families, and the American people, to help make sure that their personal information is protected against the growing threat of cybercrime."

That was the opening sentence of our prior Semiannual Report to Congress. At that time, I was discussing the recent string of cyber attacks against health insurance carriers participating in the Federal Employees Health Benefits Program. Unfortunately, I must return to the issue of information technology (IT) security in the aftermath of the largest and perhaps most damaging data breach ever experienced by the Federal Government at the U.S. Office of Personnel Management (OPM).

I have testified before Congress over the past several months, explaining how IT security has been a long-standing problem at OPM, and how the Office of the Inspector General (OIG) believes that OPM neglected this issue far too long. OPM's failings have been identified and extensively discussed in the public arena. It is now time for OPM, along with the Office of Management and Budget (OMB), to self-assess, and develop a master plan to move forward.

As the agency takes steps to improve its IT security protection against future attacks, I would like to take a moment to point out that OPM cannot be held solely responsible for the egregious lapses in judgment that left the agency vulnerable to attack. The truth of the matter is that cybersecurity is everyone's responsibility.

First, it is now up to this and future Administrations to take a strong leadership role and demand that Federal agencies appropriately prioritize this critical issue. This past summer, OMB initiated the "30-Day Cybersecurity Sprint," and then recently issued a Cybersecurity Implementation Plan. These efforts were aimed at taking much-needed steps to strengthen IT security across the Federal Government. Indeed, after the breach, our office likewise stopped and examined our own security posture, and immediately instituted an ongoing enhancement initiative.

While OMB's actions have raised awareness of IT security, there is still work to be done regarding the issue of an often stated, but seldom enforced concept: accountability. The most important action that OMB can take right now is to provide strong leadership on this issue. For at least the last eight years, the OIG has submitted audit reports to OMB, in accordance with the Federal Information Security Management Act, identifying serious weaknesses in OPM's IT security program. Despite this, year after year, OMB failed to require OPM to address these weaknesses. Moving forward, OMB must adopt a "zero tolerance" approach for agencies that do not aggressively protect and defend the information entrusted to them.



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The Executive Branch cannot do this alone. Congressional oversight of cybersecurity – and correspondingly, recognition of its costs – is critical. Protecting taxpayers' personally identifiable information and other sensitive data is not cheap, but it is essential and agencies must have sufficient funding to implement the tools necessary to defend the country against adversaries who wish to harm us.

Acting Director Beth F. Cobert has indicated that she understands the daunting challenges facing OPM, and expressed a strong intent to ensure that the agency takes appropriate and deliberate measures to fulfill its responsibilities to the American public. As the agency moves forward to strengthen its cybersecurity posture, the OIG will continue to provide OPM and Congress with advice and insight gathered through our oversight activities.

A handwritten signature in dark ink, reading "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 Office of the Inspector General 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 250 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 \$45.8 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) or health plans.

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 21 final audit reports on organizations participating in the FEHBP, of which 12 contain recommendations for monetary adjustments in the amount of \$58.3 million due to the OPM administered trust funds.

COMMUNITY-RATED PLANS

The community-rated carrier audit universe covers approximately 140 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates health 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 health plan charges the two employer groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups* (SSSGs). The rates are set by the health plan, which is also



responsible for selecting the SSSGs. 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 health plans select 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 health 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.*

Beginning in 2013, OPM implemented a new rating methodology that eliminated the SSSG requirements for non-traditional community-rated carriers and set a Medical Loss Ratio (MLR) threshold.

***Medical Loss Ratio (MLR)** is the proportion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected. The MLR is important because it requires health insurers to provide consumers with value for their premium payments.*

Since 2011, the Affordable Care Act (ACA) has required each large group health insurer to spend at least 85 percent of collected health insurance

premiums on clinical services and quality improvement each year or provide a rebate. This is often explained as a health plan spending a minimum of \$0.85 of every \$1.00 paid in health insurance premiums on clinical services and quality improvements, and a maximum of \$0.15 of every \$1.00 on administrative costs. Each health insurer must reimburse policyholders any difference between the MLR and the 85 percent minimum expenditure.

For the FEHBP, the basic MLR calculation equals FEHBP claims plus expenses related to quality health improvements divided by premiums. Since the claims cost is a major factor in the MLR calculation, we are now focusing our efforts on auditing the FEHBP claims used in the MLR calculation.

During this reporting period, we issued 14 final audit reports on community-rated health plans and recommended approximately \$47.7 million in premium recoveries to the FEHBP. Report summaries are provided below to highlight notable audit findings.

Health Insurance Plan of Greater New York

NEW YORK, NEW YORK

Report No. 1C-51-00-14-066

AUGUST 31, 2015

The Health Insurance Plan of Greater New York (Plan) has participated in the FEHBP since 1960, and provides health benefits to FEHBP members in the greater New York City area. The audit covered contract years 2013 and 2014. During this period, the FEHBP paid the Plan approximately \$196.2 million in premiums. The Plan uses traditional community rating and is exempt from the MLR rules described above.

Inappropriate Charges Amount to Over \$16.6 Million

In 2013 and 2014, we identified inappropriate health benefit charges to the FEHBP totaling \$16,633,324. In addition, we determined the FEHBP is due \$557,854 for lost investment income as a result of the overcharges.



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

The overcharges occurred due to the Plan:

- Using incomplete, inaccurate, and noncurrent Medicare enrollment data in its 2013 and 2014 FEHBP Medicare loading;
- Not applying the correct copay level values in the 2013 and 2014 FEHBP Medicare loading calculation; and,
- Not having adequate rating system controls to assure that prior audit findings are corrected in future rate years and that the Medicare loading applied to the FEHBP rates is developed using consistent, accurate, and current data.

not applied proportionally, appropriately, and not based on a generally accepted accounting method;

- The Plan erroneously used calendar year 2011, instead of 2012, dental claims in its MLR calculation;
- The Plan failed to remove vendor payments from incurred claims used in its MLR calculation;
- The Plan inappropriately included six pharmacy claims paid on three ineligible members during calendar year 2012 in its MLR calculation; and,
- The Plan inappropriately included 10 non-covered elective abortion claims paid during calendar year 2012, in its MLR calculation.

MLR Penalty
Underpayment
to OPM
Amounted to
Over \$20 Million

Aetna HealthFund

BLUE BELL, PENNSYLVANIA

Report No. 1C-22-00-14-071

AUGUST 31, 2015

Aetna HealthFund (Plan) has participated in the FEHBP since 2006, and provides health benefits to FEHBP members nationwide. The audit covered the Plan's MLR and rate buildup submission for contract year 2012. During this period, the FEHBP paid the Plan approximately \$416.5 million in premiums.

The Plan calculated an MLR of 88.16 percent, which was below the 89 percent threshold for the 2012 pilot year, and paid a penalty of \$3,205,977 to OPM before the deadline of August 31, 2013. However, during our review of the Plan's MLR submission, we found that the Plan underpaid its MLR penalty in the amount of \$20,016,333 due to the following:

- The Plan's method of allocating Federal income taxes to the FEHBP in the MLR calculation was

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 health benefit refunds and drug rebates;
- Effectiveness of carriers' claims processing, financial, cost accounting and cash management systems; and,
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.



During this reporting period, we issued five experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$10.6 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a Government-wide Service Benefit Plan with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP) Director's Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, BCBS plans, and OPM. The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims, maintaining a history file of all FEHBP claims, and an overall accounting for all program funds.

The 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 BCBS operations center in Washington, D.C. Approximately 64 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued four BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, cash management activities, and/or Fraud and Abuse Program activities. Our auditors identified \$10.6 million in questionable costs charged to the FEHBP contract. BCBS agreed with \$5.5 million of the identified overcharges. Summaries of two of these final reports are provided below to highlight our notable audit findings.

Horizon BlueCross BlueShield of New Jersey

NEWARK, NEW JERSEY

Report No. 1A-10-49-14-057

JUNE 18, 2015

Our audit of the FEHBP operations at Horizon BlueCross BlueShield of New Jersey (Plan) covered miscellaneous health benefit payments and credits from 2009 through February 2014, as well as administrative expenses from 2009 through 2013. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2009 through February 2014 and the Plan's Fraud and Abuse Program from 2013 through June 2014. For contract years 2009 through 2013, the Plan processed approximately \$2.1 billion in FEHBP health benefit payments and charged the FEHBP \$106 million in administrative expenses.

We questioned \$375,650 in health benefit charges, administrative expense overcharges, cash management activities, and lost investment income (LII); and our auditors identified procedural findings regarding the Plan's cash management activities and

**Auditors Question
\$375,650 in Health
Benefit Charges,
Administrative
Expenses, Cash
Management
Activities, and Lost
Investment Income**



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Fraud and Abuse Program. The monetary findings included the following:

- \$239,723 in excess FEHBP funds held by the Plan in the dedicated FEP investment account as of February 28, 2014;
- \$62,661 for unreturned health benefit refunds, medical drug rebates, and fraud recoveries as well as \$12,949 for LII on health benefit refunds, medical drug rebates, and fraud recoveries returned untimely to the FEHBP;
- \$57,468 for LII on excess administrative expense reimbursements that were returned untimely to the FEHBP; and,
- \$2,800 for administrative expense overcharges and \$49 for applicable LII on these overcharges.

Regarding the procedural finding for cash management activities, our auditors also determined that the Plan inadvertently held excess corporate funds of \$3,946,389 in the FEP investment account as of February 28, 2014. The Plan should not maintain excess corporate (non-FEHBP) funds in the dedicated FEP investment account.

For the procedural finding regarding the Plan's Fraud and Abuse Program, we determined that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters. Specifically, the Plan did not report, or report timely, all fraud and abuse cases to OPM's OIG. The Plan's non-compliance may be due in part to:

- Incomplete or untimely reporting of fraud and abuse cases to the FEP Director's Office; and,
- Inadequate controls at the FEP Director's Office to monitor and communicate the Plan's cases to us.

Without awareness of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

The Association and Plan agreed with \$305,732 and disagreed with \$69,918 of the questioned amounts, and agreed with the procedural findings.

CareFirst BlueCross BlueShield's FEP Operations Center Costs

OWINGS MILLS, MARYLAND
AND WASHINGTON, D.C.

Report No. 1A-10-92-14-055

SEPTEMBER 11, 2015

Our audit of the FEHBP operations at CareFirst BlueCross BlueShield (Plan) covered the Plan's administrative expenses for the FEP Operations Center from 2009 through 2013. The objective of this audit was to determine whether the Plan charged administrative expenses to the FEHBP for the FEP Operations Center that were actual, allowable, necessary, and reasonable expenses incurred in accordance with the terms of the contract and applicable regulations. For contract years 2009 through 2013, the Plan charged approximately \$581 million in administrative expenses to the FEHBP for the FEP Operations Center.

We questioned \$2,795,412 in administrative expenses and applicable LII. Specifically, during our audit fieldwork phase, the Plan self-disclosed overcharges of \$2,696,644 to the FEHBP for plan employee post-retirement benefit (PRB) costs that were incurred from 2009 through 2013 for the FEP Operations Center. As a result of this finding, the Plan returned \$2,520,696 to the FEHBP, consisting of \$2,421,928 for the PRB costs overcharged to the FEHBP from 2010 through 2013 and \$98,768 for applicable LII. The Plan also submitted prior period adjustments for the 2009 PRB cost overcharges of \$274,716.

FEHBP
Overcharged
Nearly
\$2.7 Million
for Post-Retirement
Benefit Costs



The Association and Plan agreed with the questioned amounts for the PRB cost overcharges and applicable LII.

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 did not issue any audit reports on employee organization plans during this reporting period.

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.

Members of experience-rated plans have the option of using a designated network of providers or using out-of-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 an out-of-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued one experience-rated comprehensive medical plan audit report during this reporting period, which is highlighted below.

CareFirst BlueChoice

OWINGS MILLS, MARYLAND

Report No. 1D-2G-00-14-054

JUNE 19, 2015

CareFirst BlueChoice (Plan) is an experience-rated HMO offering High and Standard Option plans to Federal enrollees and their families. Enrollment is open to all Federal employees and annuitants in the Plan's service area, which includes Maryland, Northern Virginia, and Washington, D.C.

The audit of the Plan's FEHBP operations covered prescription and medical drug rebates and cash management activities and practices from 2011 through April 2014. For contract years 2011 through 2013, the Plan processed approximately \$608 million in FEHBP health benefit payments and charged the FEHBP \$40 million in administrative expenses.

Our auditors identified no significant findings pertaining to prescription and medical drug rebates and the Plan's cash management activities and practices. Overall, we concluded that the Plan returned prescription and medical drug rebates to the FEHBP in a timely manner. We also concluded that the Plan handled FEHBP funds in accordance with the FEHBP contract and applicable laws and regulations concerning cash management in the FEHBP.



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 as well as provide Government-wide recruiting tools for Federal agencies and individuals seeking Federal jobs. 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, the Information Systems Audits Group evaluates historical health benefit claims data for appropriateness, and makes audit recommendations that erroneous payments be returned to OPM. We are also responsible for performing an independent oversight of OPM's internal information technology and security program, including focused audits of major OPM information systems and system development projects.

Summaries of some of the audit reports issued during this period are provided below.

Information Technology Security Controls for OPM's Multi-State Plan Program Portal

WASHINGTON, D.C.

Report No. 4A-RI-00-15-013

MAY 11, 2015

The Multi-State Plan Program (MSPP) Portal is one of OPM's critical information technology (IT) applications. As such, we evaluated the system's compliance with the Federal Information Security Management Act (FISMA).

The MSPP Portal is a web-based application designed to assist the National Healthcare Operations (NHO) office in receiving, storing, and evaluating information received from applicants who wish to become certified Multi-State Plan Issuers in the MSPP. The system was migrated from an AT&T hosted environment to OPM's Macon, Georgia hosting environment in February 2015.

Our objective was to perform an evaluation of the security controls for the MSPP Portal to ensure that NHO officials have managed the implementation of IT security policies and procedures in accordance

Opportunities
for Improvement
Exist in
NHO's Process
to Detect Security
Weaknesses



with standards established by FISMA. Although the system is compliant with FISMA requirements, NHO could improve its process for managing the MSPP Portal plan of action and milestones.

We also tested approximately 50 specific information system security controls included in the National Institute of Standards and Technology's (NIST) Special Publication 800-53 Revision 4, "Security and Privacy Controls for Federal Information Systems and Organizations." Our review identified areas where NHO could improve its process to detect and remediate security vulnerabilities in a timely manner.

Information System General and Application Controls at Group Health Cooperative and KPS Health Plans

TUKWILA, WASHINGTON

Report No. 1C-54-00-14-061

MAY 18, 2015

Our audit focused on Group Health Cooperative (GHC) and KPS Health Plan's (KPS) various claims processing applications and IT systems used to support these applications. KPS is a wholly owned subsidiary of GHC. The companies share several IT resources, policies and procedures. We documented the controls in place and opportunities for improvement in each of the areas below.

Security Management

GHC and KPS have implemented a security management program with adequate IT security policies and procedures.

Access Controls

GHC and KPS have implemented controls to prevent unauthorized logical access to its facilities. However, GHC's physical access controls over both its general facility and data center could be improved.

Network Security

GHC's and KPS' network security controls have several areas of concern:

- A patch management policy is in place, however, patches are not being implemented in a timely manner;
- A methodology is not in place to prevent the use of unsupported or out-of-date software;
- Several servers were configured in an insecure manner; and,
- KPS does not have a formal firewall management policy.

Improvements
Needed for
Access Controls,
Network Security,
Configuration
Management,
and Claims
Adjudication

Configuration Management

GHC has not developed formal configuration policies and baselines for all operating platforms used in its environment. Furthermore, GHC does not audit its configuration settings against documented baseline configurations.

Contingency Planning

GHC's and KPS' business continuity and disaster recovery plans contain the key elements suggested by relevant guidance and publications.

Claims Adjudication

GHC and KPS have implemented many controls in their claims adjudication processes to ensure that FEHBP claims are processed accurately. However, we noted weaknesses in GHC's and KPS' claims application controls.



Flash Audit Alert – OPM’s Infrastructure Improvement Project

WASHINGTON, D.C.

Report No. 4A-CI-00-15-055

JUNE 17, 2015

A Flash Audit Alert was issued to bring attention to the serious concerns that we have regarding the Office of the Chief Information Officer’s (OCIO) Infrastructure Improvement Project.

Our primary concern is that the OCIO has not followed the Office of Management and Budget (OMB) requirements and project management best practices. The OCIO has initiated this project without a complete understanding of the scope of OPM’s existing technical infrastructure or the scale and costs of the effort required to migrate it to the new environment.

Sole Source
Contract for
Infrastructure
Overhaul
Should be
Re-evaluated

In addition, we have concerns with the nontraditional Government procurement vehicle that was used to secure a sole-source contract with a vendor to manage the infrastructure overhaul. We agree that the sole-source contract may have been appropriate for the initial phases of securing the existing technical environment. However, we

do not agree that it is appropriate to use this vehicle for the long-term system migration efforts.

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

DURHAM, NORTH CAROLINA

Report No. 1A-10-33-14-062

JUNE 18, 2015

Our audit focused on BlueCross BlueShield of North Carolina’s (BCBSNC) various claims processing

applications, and IT systems used to support these applications. We documented the controls in place and opportunities for improvement in each of the areas below.

Security Management

BCBSNC has implemented a security management program with adequate IT security policies and procedures.

Access Controls

BCBSNC has implemented controls to prevent unauthorized physical access to its facilities, and logical controls to protect sensitive information. However, BCBSNC’s access controls have no technical control to detect or prevent piggybacking at BCBSNC facilities; and, the process of reviewing physical access does not require managers to acknowledge the review.

Network Security

BCBSNC has implemented an incident response and network security program. We noted several areas of concern related to BCBSNC’s network security controls. We determined that a patch management policy is in place, however, we identified several instances where patches are not being implemented in a timely manner; and, several servers and workstations contained unsupported or out-of-date software.

Configuration Management

BCBSNC has developed formal configuration management policies and baselines for its operating platforms. Furthermore, BCBSNC has a documented change control process for the documented baseline configurations.

Contingency Planning

BCBSNC’s business continuity and disaster recovery plans contain the elements suggested by relevant guidance and publications. However, we noted two



areas of concern related to BCBSNC's contingency planning controls. BCBSNC:

Areas for Improvement
Noted for BCBSNC's Access Controls, Network Security, and Contingency Planning

- Does not verify with individual business units that appropriate business continuity plan testing has occurred; and,
- The disaster recovery plan specific to its Federal line of business does not include the necessary level of detail for testing.

Claims Adjudication

BCBSNC has implemented controls in its claims adjudication process to ensure that FEHBP claims are processed accurately.

Information Technology Security Controls for OPM's Annuitant Health Benefits Open Season System

WASHINGTON, D.C.

Report No. 4A-RI-00-15-019

JULY 29, 2015

The Annuitant Health Benefits Open Season System (AHBOSS) is one of OPM's critical IT applications. As such we evaluated the system's compliance with FISMA.

AHBOSS has a web-based application component and an interactive voice response component that allows Federal annuitants to make changes or request information about health benefits coverage during open season. AHBOSS is owned by OPM's Retirement Services (RS) program office; the system is managed and operated by a contractor, General Dynamics Information Technology, and is hosted in Westminster, Colorado.

Our objective was to perform an evaluation of the security controls for AHBOSS to ensure that RS officials have managed the implementation of IT security policies and procedures in accordance with standards established by FISMA. Although the system is generally compliant with FISMA requirements, we noted that the security controls are not tested annually in accordance with OPM policy and that the process for remediating the plan of action and milestones could be improved.

We also tested approximately 35 specific information system security controls included in NIST's Special Publication 800-53 Revision 4, "Security and Privacy Controls for Federal Information Systems and Organizations." We determined that the majority of tested security controls appear to be in compliance. However, we noted several areas for improvement in the following areas: identification and authentication, physical access control, protection of information at rest, vulnerability scanning, and configuration settings.

Most Security Controls are Compliant, But Opportunities for Improvement Exist in OPM's Annuitant Health Benefits Open Season System

Audit of Global Coordination of Benefits for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-14-046

JULY 29, 2015

We conducted a limited scope performance audit to determine whether the BlueCross and BlueShield (BCBS) plans charged costs to the FEHBP and provided services to its members in accordance with the terms of the contract with OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.



FEHBP Overcharged \$7.4 Million for Claims Not Properly Coordinated with Medicare

We identified all BCBS claims incurred on or after August 2013 that were reimbursed from September 2013 through May 2014 and potentially not coordinated with Medicare. This search identified 404,775 claim lines, totaling \$49,239,602 in payments. We determined that the FEHBP was overcharged \$2,947,816

in health benefit charges for claims not properly coordinated with Medicare.

We also reviewed a statistical sample of Category F claims for patients with cumulative claim line payments less than \$2,500 and projected that the FEHBP was overcharged \$4,486,775 in health benefit charges for claims not properly coordinated with Medicare. Category F claims include outpatient facility and professional claims where Medicare Part B should have been the primary payer. We determined that the FEHBP was overcharged a total of \$7,434,591 in health benefit charges.

Information Technology Security Controls for OPM's GP Plateau Baseline 6 Learning Management System

WASHINGTON, D.C.

Report No. 4A-HR-00-15-015

JULY 31, 2015

The GP Plateau Baseline 6 Learning Management System Portal (GPB6 LMS) is one of OPM's critical IT applications. As such we evaluated the system's compliance with FISMA.

The GPB6 LMS is a web-based employee training platform. The system is designed to provide Federal agencies with an e-learning management system to develop, deliver, and track training for Federal employees. GPB6 LMS is a contractor system managed and operated by GP Strategies in Columbia, Maryland and hosted in a third party data center in Sterling, Virginia.

Our objective was to perform an evaluation of the security controls for GPB6 LMS to ensure that OPM's Human Resources Solutions (HRS) officials have managed the implementation of IT security policies and procedures in accordance with standards established by FISMA. GPB6 LMS was not authorized to operate in OPM's technical environment throughout the audit because it had not completed OPM's Security Assessment and Authorization (SA&A) process. We noted issues related to the scope of security testing as part of the ongoing SA&A. We also identified that HRS is not adequately following OPM's plan of action and milestone process and that a Privacy Impact Assessment has not been completed.

We also tested approximately 40 specific information system security controls included in NIST's Special Publication 800-53 Revision 4, "Security and Privacy Controls for Federal Information Systems and Organizations." We determined that the majority of tested security controls appear to be in compliance. However, we noted several areas for improvement in the following areas: separation of duties, publically available content, and vulnerability scanning.

Security Controls
are in Compliance;
However,
Several Areas
for Improvement
Noted in OPM's
Learning
Management
System Portal



Internal 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 Act (CFO) of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

Controls Over Retirement Eligibility and Services

WASHINGTON, D.C.

Report Number 4A-RS-00-13-033

APRIL 13, 2015

Our auditors conducted a performance audit of OPM's Retirement Services' (RS) Retirement Eligibility and Services (RES) office. The objective of the audit was to obtain reasonable assurance that RES has effective controls in place to maintain the integrity of the Federal retirement annuity roll.

RES conducts surveys and matches to determine retired annuitants' continued entitlement to benefits and researches allegations of retirement benefit fraud and misuse for potential referral to our investigators. RES also administers annual surveys and computer matches of the Federal Employees Retirement System (FERS) annuity supplement and disability benefits. The office also conducts weekly Consolidated Death and annual Death Master File matches using the Social Security Administration's (SSA) death data files.

We determined that OPM needs to strengthen its controls over its survey and matching processes, which are intended to confirm

eligibility for benefits. Our audit questioned \$57,133 in improper payments made to annuitants.

Specifically, we found that RS made improper payments of:

- \$41,748 to nine deceased annuitants who were identified in the Consolidated Death Match but were not dropped from the annuity roll; and,
- \$15,385 to one annuitant identified in the 2011 Disability Earnings Match who was not dropped from the annuity roll.

We also identified areas where improvements can be made. RS needs to ensure that:

- FERS Annuity Supplement Surveys and matches are performed annually, in accordance with legislative requirements;
- Listings of the annuitants responding to the Disability Earnings Surveys are maintained and that supervisory reviews occur over the Disability Earnings Surveys cases;
- Determinations of continued eligibility for benefits made during the weekly Consolidated Death and annual Death Master File matches, on behalf of retired annuitants and their survivors, are accurate and deceased annuitants are not receiving benefit payments; and,
- Documented procedures are established for the selection methodology used to review disability earnings cases of annuitants who earned \$100,000 or less.

Auditors
Question
\$41,748 Paid
to Deceased
Annuitants



FY 2014 Improper Payments Reporting

WASHINGTON, D.C.

Report Number 4A-CF-00-15-025

MAY 15, 2015

In 2002, the Improper Payments Information Act (IPIA) was enacted to require that each Federal agency annually review all programs and activities that it administers and identify areas susceptible to significant improper payments. In July 2010, the

OPM
Complies
with IPERA
Guidance,
but Areas for
Improvement
Cited

Improper Payments Elimination and Recovery Act (IPERA), an amendment to the IPIA, redefined the definition of “significant improper payments” and strengthened executive branch agency reporting requirements. IPERA and the OMB require agency Inspectors General to annually review their agency’s improper payments reporting in the Agency

Financial Report (AFR) for compliance with IPERA.

The IPERA criterion for compliance includes requiring agencies to:

- Publish an AFR or Performance and Accountability Report (PAR) for the most recent Fiscal Year (FY) and post the report, and any accompanying materials required by OMB, on the agency’s website;
- Conduct program-specific risk assessments of each program or activity that conforms with the United States Code;
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment;
- Publish programmatic corrective action plans in the AFR or PAR;
- Publish and meet annual reduction targets for each program assessed to be at risk and measured for improper payments; and,

- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR or PAR.

We conducted a performance audit of OPM’s FY 2014 improper payments reporting for compliance with IPERA. Our objective was to determine if OPM’s reporting in the FY 2014 AFR complied with IPERA requirements. OPM received approval from OMB to exclude its Federal Investigative Services Background Investigations and Federal Employees’ Group Life Insurance programs from improper payments reporting. Therefore, our audit focused on OPM’s improper payments reporting for the Retirement Services and Healthcare and Insurance programs.

We found that OPM was in compliance with IPERA for FY 2014 improper payments reporting; however, we identified two areas of improvement concerning OPM’s internal controls over improper payments reporting. During our review, we found that improper payments information in the AFR was inaccurately reported. Specifically, we identified several inaccuracies between what was reported in the FY 2014 AFR and the supporting documentation that we obtained from OPM’s program offices. In addition, we also found that some information in the AFR was insufficient or unsupported.

Human Resources Solutions’ Pricing Methodologies

WASHINGTON, D.C.

Report Number 4A-HR-00-13-055

JUNE 2, 2015

Our auditors conducted a performance audit of the Human Resources Solutions’ pricing methodologies. Our audit objective was to assess how HRS develops their prices for products and services. This was accomplished by evaluating HRS’s pricing models to determine if they were accurately recovering costs of products and services they provide.



HRS provides products and services that assist Federal agencies in achieving their missions. This is done by helping agencies provide human resource solutions to develop leaders, develop a “high quality” sector workforce, and transform agencies into high performing organizations. HRS also assists agencies in attracting and acquiring specific talent. HRS operates under OPM’s Revolving Fund Authority which allows HRS to perform personnel management services at an agency’s request. As a Revolving Fund program, HRS recovers costs of its operations by managing agency reimbursable agreements from Federal customers.

Our audit revealed that HRS needs to strengthen its controls to ensure that fees charged to customer agencies are accurately recovering costs of products and services. Specifically, we found that additional supporting documentation is needed as discussed below.

Pricing methodologies were not fully supported:

- The Resource Management Group of HRS did not have documented policies and procedures outlining how they developed their pricing methodologies; was unable to explain how

they allocated the Cost Pool 4 (expense) amounts to HRS programs; and allocated \$708,000 more than the Cost Pool 4 amount shown on the supporting documents provided; and,

- Four program areas did not have sufficient documentation to support their pricing methodologies.

Prices for FY 2013 and 2014 services were not fully supported:

- The Administrative Law Judges program area provided supporting documents that did not directly relate to most of the expense categories used in Cost Pools 1 and 2 for FY 2013; and,
- Five program areas did not have sufficient documentation to support prices charged to customers in FY 2014.

HRS concurred with four of our recommendations and did not concur with one. For the one non-concurrence HRS offered an alternate corrective action.

Support Not
Maintained for
HRS Pricing
Methodologies



Special Audits

In addition to health insurance and retirement programs, 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 designations of contributing employees, and audits of Tribal enrollments into the FEHBP.

PHARMACY BENEFIT MANAGERS

Various health carriers participating in the FEHBP have entered into Government-wide Service Benefit Plan contracts with OPM to provide health benefit plans authorized by the Federal Employees Health Benefits Act. To further enhance Federal employees' benefits, these carriers have contracted with PBMs to provide prescription drug benefits. The PBMs provide pharmacy benefits, process pharmacy claims, and pay pharmacy providers on behalf of their contracted health carriers.

During this reporting period, we issued one final audit report on the program for contract years 2012 and 2013.

BlueCross and BlueShield Association's Pharmacy Operations as Administered by Caremark PCS Health LLC for Contract Years 2012 and 2013

SCOTTSDALE, ARIZONA

Report No. 1H-01-00-14-067

AUGUST 12, 2015

We conducted a review of the BlueCross and BlueShield Association's (BCBSA) pharmacy operations as administered by Caremark PCS

Health LLC (Caremark) for contract years 2012 and 2013. The primary objective of this audit was to determine whether costs charged to the FEHBP and services provided to FEHBP members were in accordance with the terms of the contracts between OPM and BCBSA and BCBSA and Caremark, and the Federal regulations. Our audit included a review of administrative fees, pharmacy claims pricing, eligibility, contract performance standards, and rebates for contract years 2012 and 2013, along with fraud and abuse reporting for contract year 2013.

To further enhance Federal employees' benefits under the FEHBP, insurance carriers have contracted with PBMs to provide both mail order and retail prescription drug benefits. PBMs are primarily responsible for processing and paying prescription drug claims. In this case, the PBM was used by BCBSA, on behalf of its participating BCBS plans, to develop, allocate, and control costs related to its pharmacy benefits program. BCBSA's pharmacy operations and responsibilities under the contract are carried out by the PBM (Caremark).

Duplicate
Claims Were
Not Identified
by Caremark's
System of Edits



The audit questioned \$5,915 related to duplicate claim payments and identified one procedural finding related to the Plan's fraud and abuse case reporting. Specifically, we found:

- Caremark did not identify and reverse 49 duplicate claims, resulting in a \$5,915 overcharge during contract year 2012; and,
- The BCBSA did not report to OPM's OIG all of the fraud and abuse cases that were reported to it by Caremark for contract year 2013. Additionally, of those cases that were reported to the OIG, 54 percent were not reported within the 30 working day requirement.

BCBSA and Caremark agreed with our audit findings and recommendations and worked with OPM to resolve the audit issues addressed in our report. Ultimately, BCBSA implemented corrective actions sufficient to close the audit recommendations.

DENTAL AND VISION INSURANCE PROGRAM

The Federal Employees Dental and Vision Benefits Enhancement Act of 2004 established a dental and vision benefits program for Federal employees, annuitants, and their eligible family members. In 2014, OPM awarded 10 dental and 4 vision contracts to participating insurance carriers. Each contract has a seven year performance period.

During this reporting period, we issued one final audit report on the program for contract years 2009 through 2013.

MetLife Federal Dental Plan as Administered by Metropolitan Life Insurance Company for Contract Years 2009 through 2013

ORISKANY, NEW YORK AND
BRIDGEWATER, NEW JERSEY

Report No. 1J-0F-00-14-075

JUNE 2, 2015

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 established a dental benefits and vision benefits program for Federal employees, annuitants, and their eligible family members. The Federal Employees Dental Vision Insurance Program (FEDVIP) carriers signed contracts with OPM to provide dental and vision insurance services for a term of seven years.

In August 2006, OPM awarded a contract to the Metropolitan Life Insurance Company (MetLife) to administer dental benefits under the FEDVIP. The primary objective of this audit was to determine whether costs charged to the FEDVIP and services provided to members were in accordance with the terms of the contract between OPM and MetLife. Our audit included a review of cash management activities, performance guarantees, rate proposals, administrative expenses, and claims processing for contract years 2009 through 2013.

The audit identified three procedural findings related to performance guarantees, administrative expenses, and claims processing. Specifically, we found MetLife's:

- 2009 through 2013 annual performance results were inaccurately reported to OPM due to calculation errors;
- Administrative expenses reported in its 2009 through 2013 certified annual accounting statements were understated by \$1,610,920; and,
- 2009 through 2013 benefit brochures erroneously excluded coverage for an allowable benefit.

MetLife agreed with our audit findings and recommendations and worked with OPM to resolve the issues addressed in this report. Ultimately, MetLife implemented corrective actions sufficient to close the audit recommendations.

Enforcement Activities



Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$1 trillion 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 nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$133 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 and contractor misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our criminal investigations led to 7 arrests, 13 indictments and informations, 10 convictions and \$32,592,655 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 \$116,700 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 statistical summary of our office's investigative activity, refer to the table on page 35.

We use an Investigations Tracking System to maintain our investigative case files and to track the data required for this report. Unfortunately, our Investigations Tracking System was offline from June 22, 2015 until the end of the reporting period. This presented significant challenges to our Office of Investigations. Lack of access to investigative case files impeded our investigations, hampered the collection of statistics for this report, and made it necessary to temporarily suspend the closing of cases while the Investigations Tracking System was offline. Any errors or omissions in this report resulting from the unavailability of our Investigations Tracking System will be corrected in our next semiannual report.

HEALTH CARE FRAUD CASES

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 and civil 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 cases that involve harm to the patients, pharmaceutical fraud, and the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

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.



Enforcement Activities

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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

Michigan Oncologist Sentenced to 45 Years Imprisonment

A Detroit area hematologist-oncologist was sentenced to serve 45 years in prison for his role in a health care fraud scheme that included administering medically unnecessary infusions or injections to 553 individual patients and submitting approximately \$34 million in fraudulent claims to Medicare, the FEHBP, and private insurance companies.

The physician pleaded guilty in September 2014 to health care fraud, conspiracy to pay or receive kickbacks, and money laundering. He was also ordered to forfeit \$17.6 million.

The physician was a licensed medical doctor who owned and operated a cancer treatment clinic, which had seven locations throughout Michigan. He also owned a diagnostic testing facility.

In connection with his guilty plea, the physician admitted to prescribing and administering unnecessary aggressive chemotherapy, cancer treatments, intravenous iron and other infusion therapies to patients in order to increase his billings to Medicare, the FEHBP, and other insurance companies. He then submitted fraudulent claims to Medicare, the FEHBP, and other insurers for these unnecessary treatments. He also admitted to soliciting kickbacks from a hospice and a home healthcare service in exchange for his referral of patients to those facilities.

Restitution has not yet been ordered due to the vast number of victims, however the FEHBP is expected to receive over \$1.2 million. This was a joint investigation with the Federal Bureau of Investigation (FBI).

Our office debarred the oncologist from participation in the FEHBP. For additional details about this debarment action, refer to page 27 in the administrative sanctions activities section of this report.

Inspire Settles Off-Label Marketing Allegations

In June 2015, the United States Government reached a multi-million dollar settlement with Inspire Pharmaceuticals, Inc. (Inspire). The agreement resolves allegations that Inspire, located in Illinois, violated state and Federal False Claims Act laws by illegally marketing the drug Azasite for off-label uses not approved by the Food and Drug Administration (FDA). A topical antibiotic, Azasite was approved by the FDA in 2007 solely for the treatment of bacterial conjunctivitis, an eye infection commonly known as "pink eye." Under the settlement, Inspire agreed to pay the Federal and state Medicaid programs \$4.9 million, which includes civil restitution for damages to the state Medicaid programs and other Federal healthcare programs.

The settlement resolves allegations that Inspire caused the submission of false claims for reimbursement by the Medicaid program and other Federal programs by illegally promoting Azasite for the treatment of blepharitis, an inflammation of the eyelash follicles along the edge of the eyelid, notwithstanding that Azasite had not been approved by the FDA to treat this condition. Blepharitis is typically treated with warm compresses and lid scrubs, not pharmaceuticals. While physicians are permitted to prescribe drugs for conditions other than those for which the drugs have been approved by the FDA, pharmaceutical companies are prohibited from marketing drugs to physicians for such off label conditions. It is contended that, as a result of



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Inspire's illegal off label promotion, Inspire caused the submission of false and fraudulent claims for Azasite to the Medicaid program and other Federal programs.

This was a joint investigation with the Department of Health and Human Services (HHS) OIG and our office. As a result of the settlement, the FEHBP will receive \$584,531.

NuVasive Agrees to Pay \$13.5 Million to Resolve False Claims Allegations

In August 2015, NuVasive, Inc. (NuVasive) agreed to pay the Government \$13.5 million to resolve allegations that the company caused health care providers to submit false claims to Medicare and other Federal health care programs for spine surgeries by marketing the company's CoRoent System for surgical uses that were not approved by the FDA. For programs other than the FEHBP, the settlement further resolves allegations that NuVasive paid kickbacks to induce physicians to use the company's CoRoent System.

The Government alleged that between 2008 and 2013, NuVasive promoted the use of the CoRoent System for surgical uses that were not approved or cleared by the FDA, including for use in treating two complex spine deformities, severe scoliosis and severe spondylolisthesis. As a result of this conduct, the Government alleged that NuVasive caused physicians and hospitals to submit false claims to Federal health care programs for certain spine surgeries that were not eligible for reimbursement. As a result of the settlement of these false claims allegations, the FEHBP will receive \$467,483.

The settlement agreement also resolved allegations that NuVasive knowingly offered and paid illegal remuneration to certain physicians to induce them to use the CoRoent System in spine fusion surgeries, in violation of the Federal Anti-Kickback Statute. The FEHBP recovered no damages relative to these allegations, due to the exclusion of the FEHBP from

the Anti-Kickback Statute. Nevertheless, the FEHBP was affected by the payment of kickbacks, which consisted of promotional speaker fees, honoraria and expenses relating to physicians' attendance at events sponsored by a group known as the Society of Lateral Access Surgery (SOLAS). SOLAS was allegedly created, funded and operated solely by NuVasive, despite its outward appearance of independence. If the FEHBP were not excluded from the Federal Anti-Kickback Statute, we estimate the FEHBP may have recovered an additional \$121,600 from this settlement to compensate for damage caused to the FEHBP by NuVasive's alleged payment of kickbacks.

The Federal Anti-Kickback Statute made it illegal for health care providers to knowingly and willfully accept bribes or other forms of remuneration in return for generating "Federal health care program business," with the notable exception of the FEHBP, which was excluded. As a result, the FEHBP is the only Federally-sponsored health care program lacking a statute which specifically renders kickbacks illegal. It is our position that the FEHBP's exclusion from the Anti-Kickback Act should be revoked, through amendment to Title 42, United States Code, Sections 1320a – 7b(b).

This case was a joint investigation conducted by the HHS OIG, the FDA, and our office.

Pharmacy CEO Guilty of Committing Health Care Fraud

The Chief Executive Officer (CEO) of Kentwood Pharmacy pled guilty to a conspiracy to commit health care fraud based on billing Medicare Part D Plans, Medicaid, and private insurance plans for misbranded and adulterated drugs and was sentenced to a 10 year prison term. At a sentencing hearing in Grand Rapids, a Chief U.S. District Judge also ordered that the CEO serve three years of supervised release following his prison term.



Following the execution of Federal search warrants in November 2010, and the execution of an Immediate Suspension Order by the Drug Enforcement Agency (DEA), Kentwood Pharmacy ceased operations. As a result of the subsequent investigation, 18 employees at Kentwood Pharmacy were convicted of criminal offenses stemming from the practices at Kentwood Pharmacy, including the felony convictions of six licensed pharmacists. The sentences for these defendants included 14 years in prison for Kentwood Pharmacy's Vice President of Sales, for his involvement in the health care fraud conspiracy and a separate charge of possession of child pornography. The chief pharmacist was also sentenced to six years imprisonment for his role in the conspiracy.

The process by which Kentwood Pharmacy returned drugs to pharmacy stock resulted in the cross-contamination of drugs, improper labeling of drugs, the placement of different drug dosages into stock bottles, and the placement of incorrect drugs into stock bottles. These practices also allowed the removal of returned controlled substances from the pharmacy, including Vicodin and OxyContin, and illegally selling the drugs on the street in northern Michigan.

Public and private insurers paid more than \$79 million for adulterated and misbranded drugs that were sent to patients at more than 800 nursing and adult foster care homes serviced by Kentwood Pharmacy from 2006 to 2010. Based on the licensing of Kentwood Pharmacy in the name of the CEO's wife, who had nothing to do with running the pharmacy, the judge found that the business was "conceived in fraud" and "should never have received a pharmacy license."

Restitution has not yet been ordered due to the vast number of victims; however, the FEHBP is expected to receive over \$400,000. This was a joint investigation by the FBI, the FDA, and the OPM OIG.

Nine Florida Hospitals and an Ambulance Company Settle False Claims Allegation for \$7.5 Million

In May 2015, the Federal Government settled allegations that nine of the twelve largest hospitals in Jacksonville, Florida had a practice of routinely certifying and ordering basic life support ambulances even when not medically necessary. The Government also settled allegations with one Jacksonville, Florida ambulance company for its role in submitting millions of dollars of false claims to the Federal healthcare programs. The allegations resolved included liability under the False Claims Act (FCA).

After a multiple-year investigation, the Government announced settlements with four defendants:

- Baptist Health which owns and operates four hospitals in Jacksonville (settlement of \$2.89 million);
- Hospital Corporation of America which owns and operates four hospitals in Jacksonville (settlement of \$2.37 million);
- UF Health Jacksonville (settlement of \$1 million); and,
- Century Ambulance Service (settlement of \$1.25 million).

In reaching this settlement, the parties resolved allegations that, from January 2009 until April 2014, the hospitals certified claims for basic life support, non-emergency ambulance transports even when these transports were not medically necessary. With respect to Century Ambulance, the parties resolved allegations, for the same time period, that it knowingly up-coded claims from basic to advanced life support, and unnecessarily transported patients to their homes in an "emergent" fashion.



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The settlement involved false claims submitted to the FEHBP, TRICARE, and the Medicare and Medicaid programs. This case was initiated by the filing of a qui tam lawsuit. As a result of the settlement, OPM received approximately \$155,000. This case was worked jointly by the FBI, the HHS OIG, Defense Criminal Investigative Service (DCIS), and the OPM OIG.

Two Convicted of Defrauding Insurance Providers for Unnecessary Medical Procedures

A Federal jury convicted two Southern California residents in connection with a scheme to defraud union and private health insurance programs by submitting medical bills for more than \$71 million – and receiving over \$50 million in payments – for medically unnecessary procedures performed on insurance beneficiaries who received free or discounted cosmetic surgeries.

The evidence presented during the trial showed that members of the scheme lured insured “patients” to a surgery center with promises that they could use their union or preferred provider organization (PPO) health insurance plans to pay for cosmetic surgeries, which are generally not covered by insurance.

Marketers referred “patients” to the surgery center, where they were told they could receive free or discounted cosmetic surgeries if they underwent multiple, medically unnecessary procedures that would be billed to their union or PPO health care benefit program. A consultant at the surgery center scheduled procedures after telling the “patients” about the free cosmetic procedures they could receive and coached them to fabricate or exaggerate symptoms so that their medical procedures would be covered by their insurance.

The unnecessary procedures typically performed on the “patients” were endoscopies, colonoscopies, and cystoscopies. Once the health care benefit program paid the claims, the patients were given

free or discounted cosmetic surgeries, including tummy tucks, breast augmentations, and liposuction. For example, the surgery center billed tummy tucks, as if they were medically necessary procedures, such as hernia surgeries.

The two defendants sentenced were the consultant, who was sentenced to 41 months in Federal prison and ordered to pay \$2.6 million in restitution; and, the marketer who was sentenced to 5 months in prison and ordered to pay restitution of \$85,000.

As a result of the conviction, the FEHBP will receive \$73,362. This was a joint investigation by the FBI, the United States Department of Labor (DOL) OIG, the DOL Employee Benefits Security Administration, and the OPM OIG.

New York Physician Agrees to \$8 Million Settlement for Improper Billing

In July 2015, a Staten Island physician accused of improperly billing Medicare and other Government health programs for millions of dollars in diagnostic tests and treatments agreed to pay over \$8 million as part of a civil fraud settlement.

The board certified obstetrician and gynecologist with offices in Staten Island and Brooklyn, was accused of billing for diagnostic procedures and physical therapy that did not qualify for reimbursement because it was performed by unlicensed staff while he was out of the office. From 2007 to 2013, the physician billed Medicare and other Government health programs nearly \$9.5 million for diagnostic services and more than \$1.5 million for physical therapy services that were not eligible for reimbursement. The physician’s employees often performed urodynamic testing while he was out of the office — either performing surgeries at hospitals in the New York City area or traveling outside of the country — and without the direct supervision of another physician. The physician also instructed his medical assistants, who were not licensed physical therapists, to perform



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physical therapy on female patients experiencing incontinence, according to court documents.

If the physician complies with the terms of the \$8 million civil settlement agreement and abides by all terms of a deferred prosecution agreement for two years, his criminal charge of making false statements to Medicare will be dismissed.

This case was jointly investigated by the HHS OIG and our office. As a result of the settlement, the FEHBP received \$63,669 in restitution.

Orbit Agrees to \$7.5 Million Settlement for False Medical Claims

In May 2015, Orbit Medical and its partial successor, Rehab Medical, agreed to pay \$7.5 million to settle allegations that it altered and forged physician prescriptions and supporting documentation for power wheelchairs and accessories.

The settlement with Orbit Medical and Rehab Medical resolves allegations that Orbit sales representatives knowingly altered physician prescriptions and supporting documentation to get Orbit's power wheelchair and accessory claims paid by Medicare, the FEHBP, and the Defense Health Agency. In particular, the Government alleged that Orbit sales representatives changed or added dates to physician prescriptions and chart notes to falsely document that the prescription was sent to the supplier within 45 days of the face-to-face beneficiary exam; changed the physician prescription to falsely establish medical necessity for the power wheelchair or accessory; created or altered chart notes and other documents to falsely establish the medical necessity of the power wheelchair or accessory; forged physician signatures on prescriptions and chart notes; and, added facsimile stamps to supporting documentation to make it appear as though the physician's office had sent the documents to Orbit.

This case was worked jointly by HHS OIG, the FBI, DCIS and the OPM OIG. As a result of the settlement, the FEHBP will receive \$55,290.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). The most common type of retirement fraud involves the intentional receipt and use of Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS) annuity benefit payments by an unentitled recipient. However, retirement fraud can also include incidents of elder abuse.

Our Office of Investigations uses a variety of approaches to identify potential retirement fraud cases for investigation. We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. 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. The OIG also works proactively to identify retirement fraud.

The following retirement fraud investigations represent some of our activities during the reporting period.

RETIREMENT FRAUD CASES

Son Fraudulently Receives Deceased Survivor Annuitant's Benefit Payments

The son of a former Federal survivor annuitant failed to notify OPM of his father's death in August 2004, and knowingly stole and converted to his own use his father's Federal annuity payments to which he was not entitled. After his father's death, the son fraudulently received his father's annuitant payments for over 10 years by receiving Government checks, and later, electronic funds transfer deposits to a bank account to which he had no legal access.



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In June 2015, the son pled guilty to theft of \$197,012 in Federal funds. In September 2015, he was sentenced to 48 months probation with the requirement of 120 days served in home detention. He was also ordered to make full restitution to the OPM trust fund.

This case was referred to our office by OPM's Retirement Inspections office.

Daughter Continues Use of Deceased Annuitant's Benefit Payments

In July 2015, a Norfolk, Virginia area woman, who is the daughter of a deceased Federal annuitant, was sentenced to 3 years of probation with a special condition of 300 consecutive days of home detention for fraudulently securing payment when no payment was authorized in conjunction with her mother's Civil Service Retirement annuity. The court ordered payment of a \$100 special assessment fee and \$26,467 in restitution to the OPM Trust Fund.

Our investigation found that since her mother's death in 2001, the daughter and guardian of the Federal annuitant's bank account had been withdrawing funds on a monthly basis for her own personal benefit.

This was a joint investigation with the SSA OIG and our office.

Bank Returns Overpayments of Deceased Annuitant's Benefit Payments to OPM's Trust Fund

Our office was notified in September 2014 of potential fraud regarding Civil Service Retirement annuity payments. We conducted a preliminary investigation and confirmed that the annuitant had died in September 1994 and that overpayments had continued until September 2013 totaling \$54,719. Our investigation determined that a financial institution had attempted to make payment to the United States

Treasury. However, the putative payment was never received by OPM.

Our office found no evidence of fraud and subsequently coordinated with the bank to arrange a re-issuance of the aforementioned payment.

In April 2015, our office was able to recover \$46,111 of the overpayment and coordinate with OPM's Debt Management team for the remaining balance.

OIG Resolves Return of Annuitant's Benefit Payments

For nearly five years after her mother's death, the daughter of a Federal annuitant repeatedly attempted to contact OPM to rectify the overpayment issue surrounding her mother's Federal annuity. Unsuccessful, the daughter resigned her efforts until contacted by OIG special agents.

In June 2015, OIG special agents interviewed the daughter following a fraud referral from OPM's Retirement Inspections team, only to learn of the daughter's efforts to advise OPM of the overpayments. Following the preliminary investigation, OIG special agents were able to recover \$37,000, deferring the remaining balance of \$5,716 to OPM's Debt Management team for collection.

REVOLVING FUND PROGRAM INVESTIGATIONS

Our office investigates OPM employee and contractor misconduct and other wrongdoing, including allegations of fraud within OPM's Revolving Fund programs, such as the background investigations program 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 95 percent of all personnel background



April 1, 2015 – September 30, 2015 **Enforcement Activities**
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investigations for the Federal Government. With a staff of over 8,200 Federal and contract employees, FIS processed over 2.4 million background investigations in FY 2015. 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 criminal investigators include contract violations, as well as fabrications by OPM 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 and public trust 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 criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following Revolving Fund investigations represent some of our activities during the reporting period.

USIS Agreed to Settle Allegations of False Claims Act Violations

In September 2015, U.S. Investigations Services Inc. (USIS) and its parent company, Altegrity, Inc. agreed to settle allegations that USIS violated the False

Claims Act (FCA) for conduct involving a contract for background investigations that USIS held with OPM. The companies have agreed to forgo their right to collect payments that they claim were owed by OPM, valued at least at \$30 million, in exchange for a release of liability under the FCA.

From its privatization in 1996 until September 2014, USIS provided background investigations services for OPM under various fieldwork contracts. The Government alleged that beginning in at least March 2008 and continuing through at least September 2012, USIS deliberately circumvented contractually required pre-submission quality reviews of completed background investigations in order to increase the company's revenues and profits. Specifically, USIS allegedly devised a practice referred to internally as "dumping" or "flushing," which involved releasing cases to OPM and representing them as complete when, in fact, not all the reports of investigations comprising those cases had received a contractually-required pre-submission quality review. The Government contended that, relying upon USIS' false representations, OPM issued payments and contract incentives to USIS that it would not otherwise have issued had OPM been aware that the background investigations had not gone through the pre-submission quality review process required by the contracts.

The settlement was the result of a coordinated effort by the DOJ's Civil Division's Commercial Litigation Branch, the U.S. Attorney's Office of the District of Columbia, the U.S. Attorney's Office of the Middle District of Alabama, OPM's FIS, and our office.

Former Contract Investigator Falsified Numerous Background Investigations

In April 2013, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM contract background investigator.



Enforcement Activities

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From March 2010 through October 2010, the contract background investigator indicated that he had interviewed a source or reviewed a record relating to the subject of the background investigation, when in fact, he had not conducted the interview or obtained the record of interest. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

Our criminal investigators reviewed numerous case reports, records, and contacted sources to confirm that the contract background investigator did not conduct interviews as indicated in his reports of investigation. The contract background investigator was also interviewed but denied intentionally falsifying source interviews and/or records of interest.

In March 2015, the case was declined for criminal prosecution by the Department of Justice. In May 2015, an administrative contractual offset of \$183,234 to the OPM Revolving Fund was requested against USIS, the employer of the former contract background investigator. Ultimately, the Government reached a settlement with USIS in September 2015, as described previously in this report.

Former Contract Background Investigator Falsified Records

In August 2014, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM contract background investigator.

From March 2012 through March 2013, the contract background investigator indicated that he had interviewed a source or reviewed a record relating to the subject of the background investigation, when in fact, he had not conducted the interview or obtained

the record of interest. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

Our criminal investigators reviewed numerous case reports, records, and contacted sources to confirm that the contract background investigator did not conduct interviews as indicated in his reports of investigation. The contract background investigator was interviewed and admitted that pressure to complete background investigations quickly led to him and other investigators cutting corners to meet case deadlines. Although admitting to making mistakes and mishandling his cases towards the end of his employment, he denied intentionally falsifying source interviews and records of interest.

In March 2015, the case was declined for criminal prosecution by the Department of Justice. In May 2015, an administrative contractual offset to the OPM Revolving Fund for \$158,546 was requested against USIS, the employer of the contract background investigator. Ultimately, the Government reached a settlement with USIS in September 2015, as described previously in this report.

OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number, email address, and mailing address are listed on our OIG Web site at www.opm.gov/oig, along with an online anonymous complaint form. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans. Those who report information to our Hotline can do so openly, anonymously, and confidentially without fear of reprisal.



April 1, 2015 – September 30, 2015 **Enforcement Activities**

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

The information we receive on our OIG Hotline generally concerns customer service issues, FEHBP health care fraud, retirement fraud, and other complaints that may warrant investigation. 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.

We received 868 hotline inquiries during the reporting period, with 295 pertaining to health care and insurance issues, and 573 concerning retirement or special investigation.

Debarment Initiative Update

Effective March 2013, OPM implemented a new suspension and debarment program, which is separate from OIG's administrative sanctions of FEHBP health care providers. The new program covers the debarment of OPM contractors and employees who have violated the terms of their contract or employment. During this reporting period, the OIG referred 11 cases to the agency for debarment action, for a total of 70 referrals since the inception of the program. OPM issued debarment letters to 17 individuals between April 1, 2015 and September 30, 2015. The majority of cases we

refer for debarment action have been former FIS employees and contractors. Most of these former FIS employees and contractors are referred to us through FIS' internal controls program. Although these individuals were removed from Government employment or from the relevant OPM contract, we feel that Government-wide contract debarment action for these individuals is necessary to protect the integrity of Federal programs.

Our office will continue to develop and refer cases where we believe a Government-wide debarment is necessary in order to protect the integrity of OPM, as well as other Federal agencies and programs.

Correction to Prior Period Investigative Reporting Error

In our semiannual report for the period ending March 31, 2015, we inadvertently reported that OPM issued debarment letters to 17 individuals between October 2014 and March 2015. However, we have since found out that OPM actually issued debarment letters to 19 individuals during that timeframe.

We also underreported OIG administrative financial recoveries by \$50,662 resulting from a deceased retirement annuitant case.



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 33,731 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 479 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 2,839 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.

Michigan Oncologist Debarred After Guilty Plea to Patient Abuse

Our Office of Investigations (OI) referred to the administrative sanctions staff a case involving an oncologist who intentionally misdiagnosed patients in order to fraudulently bill Government health care programs and private insurance companies. The physician owned and operated seven cancer treatment centers throughout Michigan.



April 1, 2015 – September 30, 2015 **Enforcement Activities**
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In 2014, to avoid prosecution by indictment, the oncologist waived trial by jury and pled guilty to prescribing and administering aggressive chemotherapy, intravenous iron, and other infusion therapies to patients who did not need them in order to increase his billings to health care insurers, and Federal health care programs including the FEHBP. In September 2014, he was convicted and sentenced to 45 years in prison and ordered to forfeit \$17.6 million.

The physician's conviction constitutes a mandatory debarment under OPM's statutory authority. We debarred the physician for fifteen years based on the aggravating factors in this case, which include his FEHBP exposure; level of culpability; and, the seriousness of his underlying conduct and impact on the physical, mental well-being of the participants of the Federal health care programs. In addition, the doctor's actions occurred over an extended period of time where he amassed large monetary sums by defrauding the Federal programs.

More details concerning this case and its legal consequences appear in the investigations activity section of this report on page 18.

Ohio Physician Debarred After Medical License Revoked for Sexual Misconduct

Based on a referral from our OI, we debarred an Ohio physician specializing in pain management, in August 2015. Our debarment was based on the State Medical Board of Ohio's (Board) revocation of the physician's medical license. The physician admitted to the allegations contained in the Board's September 2013, Notice of Opportunity for Hearing regarding professional misconduct involving patient care, and voluntarily surrendered his license to avoid further formal disciplinary proceedings. The Board accepted the surrender, and issued an order to permanently revoke the physician's Ohio license.

In July 2013, a civil lawsuit was filed against the physician by multiple patients accusing him of nonconsensual touching during medical office appointments. The physician knew these patients were substantially impaired by advanced age, and with either a medical or mental condition.

In August 2013, the Board's Notice of Summary Suspension and Opportunity for Hearing (Notice) cited the physician for violation of several Sections of the Ohio Revised Code. The Board's Notice immediately suspended him from practicing medicine to protect the health and safety of the public, pending a formal hearing. The Board's Notice alleged that the physician:

- Engaged in sexual misconduct involving patients at his medical practice in violation of the Code;
- Failed to conform to the minimal standards of care of similar practitioners under the same or similar circumstances; and,
- Failed to cooperate in a medical board investigation.

During the investigations the Board also learned that while performing osteopathic manipulative therapy, some patient's ribs and collarbones had been broken. Several patients were subjected to ozone therapy, an alternative medicine procedure, which involved the injection of "triple oxygen" into a muscle without their knowledge or consent.

In August 2014, the Summit County Court of Common Pleas in Akron, Ohio found the physician guilty on one misdemeanor count of sexual imposition. He was sentenced to 59 days in jail and 5 years' probation. In addition, he is required to register as a sexual offender for the next 15 years. In October 2014, his conviction was stayed, and he was allowed to remain free pending an appeal.



Enforcement Activities

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Under OPM's statutory and regulatory authorities, the agency may debar a health care provider whose professional licensure has been revoked, restricted, or deemed nonrenewable by a state licensing authority, for reasons related to the provider's professional competence, professional performance, or financial integrity.

Due to the seriousness of the allegations against the physician and that he was paid to treat FEHBP enrollees, we concluded that sufficient evidence existed to debar. We debarred the physician for an indefinite period of time pending the adjudication of his Ohio licensure.

Texas Chiropractor and Five Co-Conspirators Debarred for Health Care Fraud

In September 2015, our office debarred a Texas chiropractor; an occupational therapist; three office managers and a patient recruiter after they were convicted of health care fraud.

From 2009 to 2012, this health care provider and five co-conspirators submitted fraudulent claims to health care insurers and Government insurance programs, including the FEHBP. The chiropractor owned and operated several rehabilitation and diagnostic facilities in Texas. It was through these facilities that the group devised and implemented their scheme to defraud health insurance programs.

The chiropractor hired a consultant to recruit patients who allowed his facilities to bill their insurers for medical services not rendered. In exchange they received monetary kickbacks and a variety of other incentives. These deceptive efforts were assisted by an occupational therapist and three office managers. To support the fraudulent claims, inaccurate and misleading information was entered into patients' records to indicate the existence of serious conditions that did not exist.

The chiropractor was convicted of multiple counts of conspiracy to commit health care fraud, and aggravated identity theft. In January 2015, he was sentenced to 12 years in prison; 3 years supervised release; and ordered to pay \$2.4 million in restitution for health care fraud.

The provider's conviction is the basis for a mandatory debarment under OPM's statutory authority. During this reporting period we imposed a twelve-year term of debarment considering the doctor's association with the FEHBP and included aggravating factors associated with his offenses, including monetary loss to the FEHBP carriers and the prolonged period during which he knowingly submitted false claims.

In addition, we debarred the 5 others who were convicted for their involvement in this health care conspiracy including an occupational therapist, 3 office managers who were each debarred for 5 years; and the patient recruiter for 13 years.



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 other OIG 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.

CONGRESSIONAL HEARINGS

In June 2015, OPM announced the discovery of a data breach resulting in the theft of the personnel data of approximately 4.2 million current and former Federal employees. Shortly thereafter, OPM announced that another breach had been discovered, which compromised background investigation records of approximately 21.5 million current, former, and prospective Federal employees and contractors.

As a result, the OIG was asked to appear before five Congressional hearings to discuss information security at OPM.

The Inspector General testified at the following hearings:

- “OPM Data Breach: Part II” before the House Committee on Oversight & Government Reform (June 24, 2015)
- “Under Attack: Federal Cybersecurity and the OPM Data Breach” before the Senate Committee on Homeland Security & Governmental Affairs (June 25, 2015)

The Assistant Inspector General for Audits testified at the following hearings:

- “OPM: Data Breach”, House Committee on Oversight & Government Reform, (June 16, 2015)
- “OPM Information Technology Spending & Data Security”, Senate Committee on Appropriations, Subcommittee on Financial Services and General Government (June 23, 2015)
- “Is the OPM Data Breach the Tip of the Iceberg?”, House Committee on Science, Space, & Technology, Subcommittees on Research & Technology and Oversight (July 8, 2015)



April 1, 2015 – September 30, 2015 **Legislative Activities**

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At the hearings, OIG witnesses discussed issues previously identified in our FY 2014 audit of OPM's IT security, conducted pursuant to FISMA. Three concerns in particular were highlighted. First, the OIG noted deficiencies in OPM's security governance. While OPM has made efforts in recent years to centralize responsibility for its IT systems in the Office of the Chief Information Officer (OCIO), the technical infrastructure remains decentralized and consequently difficult to protect.

Second, the OIG noted that 11 OPM IT systems were operating without a valid authorization in FY 2014, a requirement that ensures that each IT system meets applicable security standards before being allowed to operate in the agency's technical environment. The OIG recommended that the OPM Director consider shutting down IT systems without a valid authorization, and also include FISMA compliance requirements in the performance standards of owners of major OPM IT systems.

The OIG also discussed the concerns raised in the FISMA audit report regarding OPM technical security controls. The OIG witnesses described certain serious deficiencies in OPM's configuration management, including the agency's failure to maintain an accurate centralized inventory of its network servers and databases and its underutilization of new tools and controls designed to strengthen the agency's technical infrastructure. The OIG also called attention to the agency's incomplete implementation of personal identity verification (PIV) credentials. As of the end of FY 2014, over 95 percent of OPM workstations required PIV authentication to access the OPM network, but none of the agency's 47 major applications required the same.

During these hearings, the OIG also offered testimony regarding a massive overhaul of OPM's technical IT infrastructure, which was the subject of a June 17, 2015 Flash Audit Alert issued by our office. The OIG emphasized two major areas of concern with the project: project management deficiencies and the inappropriate use of a sole-source contract. The most significant problem with OPM's management of the IT overhaul is the agency's failure to prepare a Major IT Business Case proposal, a process mandated by the OMB that would have required OPM to evaluate the costs, benefits and risks associated with the IT overhaul. Moreover, OPM failed to follow basic best practices for program management and obligated funds for the project before securing them. The OIG also explained that the use of sole-source contract for the implementation of the IT overhaul, while warranted for the initial phase, was not appropriate for the entire length of the project. Accordingly, the OIG recommended that remaining phases of the project be procured through vehicles other than sole-source contracting, with particular consideration being given to full and open competition.

COMBATTING REPRESENTATIVE PAYEE FRAUD

If a Federal annuitant cannot manage his or her finances, OPM has the authority to make payments to a representative payee who is willing to act on behalf of the annuitant.

Recently, the OIG has noticed an increase in the number of cases where a representative payee fails to appropriately use the payments for the benefit of the annuitant, and instead converting the funds for personal use and leaving the annuitant unable to pay for essential care and treatment.



Under current law, although theft of Social Security and Veterans' benefits by a representative payee is a crime, theft of Federal annuities is not. Unfortunately, this loophole makes it difficult for the OIG to persuade Federal prosecutors to pursue cases involving representative payee fraud because it is viewed as a theft from the annuitant rather than fraud against the Federal Government. It is illogical to treat theft by a representative payee differently solely because the benefits at issue are paid by the SSA or the Department of Veterans Affairs rather than OPM.

The OIG presented this problem to our Congressional committees and they shared our concern. To that end, on June 15, 2015, Senator James Lankford introduced S. 1576, the Representative Payee Fraud Prevention Act of 2015, aimed at protecting Federal annuitants by holding such dishonest caretakers accountable. The bill was co-sponsored by Senators Heidi Heitkamp and Ron Johnson. On August 5, 2015, it was passed by the Senate by unanimous consent.

Statistical Summary of Enforcement Activities



Judicial Actions:

Indictments and Informations.	13
Arrests	7
Convictions.	10

Judicial Recoveries:

Restitutions and Settlements	\$32,592,655
Fines, Penalties, Assessments, and Forfeitures.	\$116,700 ¹

Retirement and Special Investigations Hotline Activity:

Total Received:	573
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Health Care Fraud Hotline Activity:

Total Received:	295
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Administrative Sanctions Activity:

FIS Cases Referred for Debarment and Suspension	11
Health Care Debarments and Suspensions Issued	479
Health Care Provider Debarment and Suspension Inquiries	2,839
Health Care Debarments and Suspensions in Effect at End of Reporting Period	33,731

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.

Appendix I-A Final Reports Issued With Questioned Costs for Insurance Programs

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	0	\$ 0
B. Reports issued during the reporting period with findings	12	58,301,213
Subtotals (A+B)	12	58,301,213
C. Reports for which a management decision was made during the reporting period:	11	53,814,438
1. Disallowed costs	11	53,814,438
2. Costs not disallowed	0	0
D. Reports for which no management decision has been made by the end of the reporting period	1	4,486,775
E. Reports for which no management decision has been made within 6 months of issuance	0	0



Appendix I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$2,034,259
B. Reports issued during the reporting period with findings	1	57,133
Subtotals (A+B)	6	2,091,392
C. Reports for which a management decision was made during the reporting period:	2	2,012,142
1. Disallowed costs	2	2,012,142
2. Costs not disallowed	0	0
D. Reports for which no management decision has been made by the end of the reporting period	4	79,250
E. Reports for which no management decision has been made within 6 months of issuance	3	22,117

Appendix II

Final Reports Issued With Recommendations for Better Use of Funds

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Subject	Number of Reports	Dollar Value
No activity during this reporting period	0	\$0



Appendix III Insurance Audit Reports Issued

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued	Questioned Costs
1C-GV-00-15-006	MVP Health Plan, Inc. of the Western Region in Schenectady, New York	May 18, 2015	\$ 0
1J-OF-00-14-075	MetLife Federal Dental Plan as Administered by the Metropolitan Life Insurance Company for Contract Years 2009 through 2013 in Oriskany, New York and Bridgewater, New Jersey	June 2, 2015	0
1C-DQ-00-14-051	Physicians Health Plan of Northern Indiana in Fort Wayne, Indiana	June 3, 2015	89,759
1A-10-49-14-057	Horizon BlueCross and BlueShield of New Jersey in Newark, New Jersey	June 18, 2015	375,650
1C-TV-00-14-072	Humana Coverage First of Austin, Texas in Louisville, Kentucky	June 18, 2015	171,290
1C-UW-00-15-023	UPMC Health Plan in Pittsburgh, Pennsylvania	June 18, 2015	0
1C-5E-00-14-070	Coventry Health Plan of Florida in Sunrise, Florida	June 18, 2015	230,777
1D-2G-00-14-054	CareFirst BlueChoice in Owings Mills, Maryland	June 19, 2015	0
1C-UU-00-14-073	Humana Health Plan of Texas, Inc. in Louisville, Kentucky	July 14, 2015	427,804
1A-99-00-14-069	BlueCross and BlueShield Association's Fraud Information Management System in Washington, D.C. and Chicago, Illinois	July 14, 2015	0
1C-P2-00-15-022	Presbyterian Health Plan in Albuquerque, New Mexico	July 29, 2015	0
1A-99-00-014-046	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	July 29, 2015	7,434,591
1C-QA-00-14-045	Independent Health Plan in Buffalo, New York	August 12, 2015	9,496,680
1H-01-00-14-067	BlueCross and BlueShield Association's Pharmacy Operations as Administered by Caremark PCS Health LLC for Contract Years 2012 and 2013 in Washington, D.C.	August 12, 2015	5,915
1C-K5-00-15-007	BlueCare Network of Michigan, Inc. of East Region in Southfield, Michigan	August 28, 2015	65,824
1C-51-00-14-066	Health Insurance Plan of Greater New York in New York, New York	August 31, 2015	17,191,178

**Appendix III**
Insurance Audit Reports Issued

APRIL 1, 2015 TO SEPTEMBER 30, 2015

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-22-00-14-071	Aetna Health Fund in Blue Bell, Pennsylvania	August 31, 2015	\$20,016,333
1A-10-92-14-055	CareFirst BlueCross and BlueShield's Federal Employees Program (FEP) Operations Center Costs in Owings Mills, Maryland	September 11, 2015	2,795,412
1C-LL-00-15-036	Humana Medical Plan, Inc. of Tampa in Louisville, Kentucky	September 21, 2015	0
1M-GA-00-15-005	Multi-State Plan Program Operations at Premera BlueCross and BlueShield of Alaska in Mountlake Terrace, Washington	September 21, 2015	0
1C-MJ-00-15-042	Humana Coverage First of Tampa in Louisville, Kentucky	September 21, 2015	0
TOTALS			\$58,301,213

Appendix IV
Internal Audit Reports Issued

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued
4A-RS-00-13-033	Assessing the Internal Controls over OPM's Retirement Services' Retirement Eligibility and Services Office in Washington, D.C.	April 13, 2015
4A-CF-00-15-025	OPM's FY 2014 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.	May 15, 2015
4A-HR-00-13-055	The Human Resources Solutions' Pricing Methodologies in Washington, D.C.	June 2, 2015



Appendix V Information Systems Audit Reports Issued

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued
1B-43-00-14-029	Information Systems General and Application Controls and Administrative Expenses at the Panama Canal Area Benefit Plan and its Claims Administrator, AXA Assistance in Panama City, Panama	April 2, 2015
4A-RI-00-15-013	Information Technology Security Controls of OPM's Multi-State Plan Program Portal in Washington, D.C.	May 11, 2015
1C-54-00-14-061	Information Systems General and Application Controls at Group Health Cooperative and KPS Health Plans in Tukwila and Bremerton, Washington	May 18, 2015
4A-CI-00-15-055	Flash Audit Alert -OPM's Infrastructure Improvement in Washington, D.C.	June 17, 2015
1A-10-33-14-062	Information Systems General and Application Controls at BlueCross and BlueShield of North Carolina in Chapel Hill and Durham, North Carolina	June 18, 2015
4A-HR-00-15-018	Information Technology Security Controls of OPM's USA Performance System in Washington, D.C.	July 20, 2015
4A-RI-00-15-019	Information Technology Security Controls of OPM's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015
4A-HR-00-15-015	Information Technology Security Controls of the OPM's GP Plateau Baseline 6 Learning Management System in Washington, D.C.	July 31, 2015
1C-E3-00-15-020	Information Systems General and Application Controls at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in Silver Spring, Maryland	August 28, 2015

Appendix VI Special Review Reports Issued

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued
4A-RS-00-15-014	Special Review of OPM's Quality Assessment of USIS' Background Investigations in Washington, D.C.	September 22, 2015



Appendix VII
Summary of Reports
More Than Six Months Old Pending Corrective Action
APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 1 open recommendation	April 16, 2007
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008 in Washington, D.C.; 19 total recommendations; 2 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statement in Washington, D.C.; 6 total recommendations; 1 open recommendation	November 14, 2008
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 2 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statement in Washington, D.C.; 5 total recommendations; 1 open recommendation	November 13, 2009
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 1 open recommendation	June 22, 2010
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statement in Washington, D.C.; 7 total recommendations; 3 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; 2 open recommendations	November 10, 2010
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 3 open recommendations	September 14, 2011
4A-CI-00-11-009	Federal Information Security Management Act for FY 2011 in Washington, D.C.; 29 total recommendations; 4 open recommendations	November 9, 2011
4A-CF-00-11-050	OPM's FY 2011 Consolidated Financial Statement in Washington, D.C.; 7 total recommendations; 1 open recommendation	November 14, 2011
4A-CF-00-09-014	OPM's Interagency Agreement Process in Washington, D.C.; 8 total recommendations; 2 open recommendations	March 28, 2012
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report and Receivables Tracking System in Washington, D.C.; 24 total recommendations; 12 open recommendations	July 16, 2012



Appendix VII Summary of Reports More Than Six Months Old Pending Corrective Action

APRIL 1, 2015 TO SEPTEMBER 30, 2015

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-11-067	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 6 open recommendations	September 13, 2012
4A-CI-00-12-016	Federal Information Security Management Act for FY 2012 in Washington, D.C.; 18 total recommendations; 6 open recommendations	November 5, 2012
4A-CF-00-12-039	OPM's FY 2012 Consolidated Financial Statement in Washington, D.C.; 3 total recommendations; 1 open recommendation	November 15, 2012
1K-RS-00-12-031	OPM's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.; 2 total recommendations; 1 open recommendation	December 12, 2012
1A-99-00-12-029	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 7 total recommendations; 1 open recommendation	March 20, 2013
4A-CF-00-12-066	Assessing the Relevance and Reliability of OPM's Performance Information in Washington, D.C.; 5 total recommendations; 1 open recommendation	April 1, 2013
1A-10-32-12-062	BlueCross BlueShield of Michigan in Detroit, Michigan; 11 total recommendations; 1 open recommendation	July 19, 2013
4A-CI-00-13-036	OPM's Common Security Control Collection in Washington, D.C.; 4 total recommendations; 1 open recommendation	October 10, 2013
1H-01-00-12-072	BlueCross and BlueShield's Retail Pharmacy Member Eligibility in 2006, 2007, and 2011 in Washington, D.C.; 11 total recommendations; 10 open recommendations	November 8, 2013
4A-CI-00-13-021	Federal Information Security Management Act for FY 2013 in Washington, D.C.; 16 total recommendations; 7 open recommendations	November 21, 2013
1A-99-00-13-032	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 7 total recommendations; 1 open recommendation	November 22, 2013
4A-CF-00-13-034	OPM's FY 2013 Consolidated Financial Statement in Washington, D.C.; 1 total recommendation; 1 open recommendation	December 13, 2013
1A-10-17-13-026	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois; 12 total recommendations; 2 open recommendations	January 28, 2014



Appendix VII

Summary of Reports

More Than Six Months Old Pending Corrective Action

APRIL 1, 2015 TO SEPTEMBER 30, 2015

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-14-009	OPM's FY 2013 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 1 total recommendation; 1 open recommendation	April 10, 2014
1A-99-00-13-046	Global Non-Covered Ambulance Claims for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	April 17, 2014
1B-32-00-13-037	Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia; 41 total recommendations; 10 open recommendations	May 6, 2014
4A-IS-00-13-062	The Federal Investigative Services' Case Review Process over Background Investigations in Washington, D.C.; 6 total recommendations; 6 open recommendations	June 4, 2014
1A-10-15-13-058	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 16 total recommendations; 5 open recommendations	June 6, 2014
4A-CI-00-14-015	Information Technology Security Controls of OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 6 open recommendations	June 6, 2014
1A-10-67-14-006	Information Systems General and Application Controls at Blue Shield of California in San Francisco, California; 16 total recommendations; 2 open recommendations	July 9, 2014
4A-CI-00-14-028	Status of Cloud Computing Environments within the OPM in Washington, D.C.; 3 total recommendations; 3 open recommendations	July 9, 2014
1A-99-00-13-061	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 3 open recommendations	August 19, 2014
4A-RI-00-14-036	Information Technology Security Controls of OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems FY 2014 in Washington, D.C.; 10 total recommendations; 4 open recommendations	August 19, 2014



Appendix VII Summary of Reports More Than Six Months Old Pending Corrective Action

APRIL 1, 2015 TO SEPTEMBER 30, 2015

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-14-039	OPM's FY 2014 Consolidated Financial Statement in Washington, D.C.; 4 total recommendations; 4 open recommendations	November 10, 2014
4A-CI-00-14-016	Federal Information Security Management Act for FY 2014 in Washington, D.C.; 29 total recommendations; 21 open recommendations	November 12, 2014
1A-10-70-14-007	Information Systems General and Application Controls at Premera BlueCross in Mountlake Terrace, Washington; 10 total recommendations; 2 open recommendations	November 28, 2014
3A-CF-00-14-050	The 2011 and 2012 Chesapeake Bay Area Combined Federal Campaigns of Central Maryland in Baltimore, Maryland; 24 total recommendations; 15 open recommendations	December 23, 2014
4A-CI-00-14-064	Information Technology Security Controls of OPM's Dashboard Management Reporting System in Washington, D.C.; 4 total recommendations; 3 open recommendations	January 14, 2015
1A-10-49-14-021	Information Systems General and Application Controls at Horizon BlueCross BlueShield in Newark, New Jersey; 15 total recommendations; 6 open recommendations	February 11, 2015
3A-CF-00-14-049	The 2011 and 2012 Long Island Combined Federal Campaigns in Deer Park, New York; 18 total recommendations; 16 open recommendations	February 11, 2015
1C-U4-00-14-038	The Health Plan of the Upper Ohio Valley, Inc. in St. Clairsville, Ohio; 5 total recommendations; 2 open recommendations	February 20, 2015
3A-CF-00-14-048	The 2011 and 2012 Northern Lights Combined Federal Campaigns in St. Paul, Minnesota; 29 total recommendations; 12 open recommendations	March 23, 2015
4K-RS-00-14-076	The Review of the OPM's Compliance with the Freedom of Information Act in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 23, 2015



Appendix VIII

Most Recent Peer Review Results

APRIL 1, 2015 TO SEPTEMBER 30, 2015

We do not have any open recommendations to report from our peer reviews.

Subject	Date of Report	Result
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, Board of Governors of the Federal Reserve System)</i>	September 22, 2015	Pass ²
Quality Control System Review of the U.S. Department of Commerce's Office of Inspector General Audit Organization <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	July 13, 2012	Pass ²
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Railroad Retirement Board <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	August 13, 2014	Compliant ³
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. Department of State)</i>	June 21, 2013	Compliant ³

²A peer review rating 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. The Peer Review does not contain any deficiencies or significant deficiencies.

³A rating of **Compliant** 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.



Appendices

April 1, 2015 – September 30, 2015

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Appendix IX

Investigative Recoveries

APRIL 1, 2015 TO SEPTEMBER 30, 2015

OIG Case Number	Case Category	Action ⁴	OPM Recovery (Net)	Total Recovery(All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2011 00172	Federal Investigative Services Fraud	Administrative	\$ 183,234	\$ 183,234	\$ 0
I-12-00005	Federal Investigative Services Fraud	Administrative	40,595	40,595	0
I-13-00496	Federal Investigative Services Fraud	Administrative	158,546	158,546	0
I 2011 00780	Federal Investigative Services Fraud	Civil	30,078,919 ⁴	30,078,91 ⁴	0
TOTAL	Federal Investigative Services Fraud		\$30,461,294	\$30,461,294	\$ 0
C 2011 00165	Healthcare Fraud	Civil	584,531	4,938,574	0
C-12-00445	Healthcare Fraud	Civil	18,766	1,120,299	0
C-13-00147	Healthcare Fraud	Civil	467,483	13,500,000	0
I-14-00547	Healthcare Fraud	Civil	79,659	440,232	0
C-14-00840	Healthcare Fraud	Civil	15,428	48,953	0
C-15-00482	Healthcare Fraud	Civil	63,670	8,047,291	0
I 2011 00782	Healthcare Fraud	Civil	55,290	7,500,000	0
I-12-00086	Healthcare Fraud	Civil	0	1,250,000 ⁵	0
I-12-00086	Healthcare Fraud	Civil	0	2,881,590 ⁵	0
I-12-00086	Healthcare Fraud	Civil	13,860	1,000,000	0
I-12-00086	Healthcare Fraud	Civil	73,506	2,378,539	0
I-12-00311	Healthcare Fraud	Civil	0	1,500,000 ⁵	0
I-12-00311	Healthcare Fraud	Civil	0	47,000,000 ⁵	0
I-12-00548	Healthcare Fraud	Civil	44,054	1,250,000	0
I 2011 00023	Healthcare Fraud	Criminal	0	0	100
I 2011 00023	Healthcare Fraud	Criminal	0	0	100
I 2011 00023	Healthcare Fraud	Criminal	0	23,390	200
I 2011 00148	Healthcare Fraud	Criminal	0	0	30,100
I 2011 00148	Healthcare Fraud	Criminal	0	0 ⁵	7,600
I 2011 00194	Healthcare Fraud	Criminal	0	0	75,075
I-13-00252	Healthcare Fraud	Criminal	0	900,000	125
I-13-00980	Healthcare Fraud	Criminal	0	0 ⁵	1,600
I-14-00298	Healthcare Fraud	Criminal	56,123	56,123	100



Appendix IX Investigative Recoveries

APRIL 1, 2015 TO SEPTEMBER 30, 2015
(Continued)

OIG Case Number	Case Category	Action ⁴	OPM Recovery (Net)	Total Recovery(All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I-14-00298	Healthcare Fraud	Criminal	\$ 0	\$ 0	\$ 100
I-14-01014	Healthcare Fraud	Criminal	73,362	2,666,336	400
I-14-01014	Healthcare Fraud	Criminal	0	0	500
I-14-01014	Healthcare Fraud	Criminal	0	0	200
TOTAL	Healthcare Fraud		\$1,545,732	\$96,501,327	\$116,200
C-15-00053	Retirement Fraud	Administrative	46,111	46,111	0
C-15-00423	Retirement Fraud	Administrative	49,000	49,000	0
C-15-01052	Retirement Fraud	Administrative	37,000	37,000	0
I-13-00960	Retirement Fraud	Criminal	141,135	192,245	100
I-14-00369	Retirement Fraud	Criminal	88,904	88,904	0
I-14-00521	Retirement Fraud	Criminal	0	0	200
I-15-00225	Retirement Fraud	Criminal	26,467	42,145	100
I-15-00546	Retirement Fraud	Criminal	197,012	197,012	100
TOTAL	Retirement Fraud		\$585,629	\$652,417	\$500
GRAND TOTAL			\$32,592,655	\$127,615,037	\$116,700

⁴OPM is not actually recovering this money, but rather benefits from not having to pay this money out.

⁵The amount of OPM's recovery has not been calculated yet. The conviction and judgment have been appealed.

Note: Cases that are listed multiple times indicate there were multiple subjects.

Appendix X Management Advisory Reports Issued by Office of Investigations

APRIL 1, 2015 TO SEPTEMBER 30, 2015

Report Number	Subject	Date Issued
P-12-00165	Management Advisory on the Processing of Foreign Claims by the Foreign Service Benefit Plan in Washington, D.C.	September 9, 2015

Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)



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Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed No Activity
Section 5 (a) (4):	Matters referred to prosecutive authorities 17-33
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period No Activity
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Section 5 (a) (7):	Summary of particularly significant reports 1-33
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Section 5 (a) (9):	Audit reports containing recommendations for better use of funds No Activity
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period 42-45
Section 5 (a) (11):	Significant revised management decisions during this reporting period No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period No Activity
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