

# SEMIANNUAL REPORT to CONGRESS

April 1, 2014 – September 30, 2014



United States  
Office of Personnel Management  
**OFFICE of the INSPECTOR GENERAL**

Office of the Inspector General



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds . . . . .	\$17,531,981
Management Commitments to Recover Funds . . . . .	\$34,130,326
Recoveries Through Investigative Actions . . . . .	\$4,199,535

*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 . . . . .	27
Evaluation Reports Issued . . . . .	1
Investigative Cases Closed . . . . .	31
Indictments and Informations . . . . .	41
Arrests . . . . .	29
Convictions . . . . .	30
Hotline Contacts and Preliminary Inquiries Complaints . . . . .	1,578
Health Care Provider Debarments and Suspensions . . . . .	520
Health Care Provider Debarment and Suspension Inquiries . . . . .	2,824



# SEMIANNUAL REPORT to CONGRESS

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# MESSAGE from the INSPECTOR GENERAL

## Special Recognition for Susan L. Ruge, Associate Counsel

Thank you Susan Ruge – your work ethic, imaginative spirit and intuitive research has given new and vibrant meaning to the superlative hard work and accomplishments of the men and women of this Office of the Inspector General.

Indeed, our organization's attention to detail, objectivity and, what we hold paramount, our independence, has never been more transparent to the Administration, the Congress and the American taxpayer, since the day you arrived. The high quality of our auditing, investigations, and management support staff are in a category best described as "Above and Beyond". Their work product has provided you a picture of dedicated service to the American taxpayer. So often you have taken that picture and with tenacity reached out to our stakeholders and so aptly framed it for all to see. Your untiring work illuminates your ideals of public service.



PHOTO COURTESY OF BONNIE AND RON RUGE

I believe that the philosophy that created the Inspector General Act of 1978, was, and continues to be one of unmatched concern over the enormity and variety of wrongdoing in our Government. Aside from what is the definitively stated agenda, there is an implied requirement that the Inspector General be energetic, proactive, and personify a spirit of cooperation and helpfulness with the management of the particular organization. I do not believe that the Inspector General position was created to be only a reactive force in finding fraud, waste and abuse.

I believe a reading of the intent of this legislation would find it totally inappropriate for someone in a high position of public trust, such as an Inspector General, to only react when wrongdoing occurs, and otherwise be complacent about providing help, guidance and counsel. To this end, your contributions have been uniquely instrumental to the success of virtually every major work product from establishing a robust Congressional Relations program, authoring major policy studies to overseeing the progress of crucial legislation for our office through Congressional consideration, passage and enactment.

Susan you are a big part of our Office's Credo: To know our business and responsibilities better than anyone else and at the close of the day to be able to say we did what was right.

A stylized, handwritten signature in dark ink that reads "Patrick E. McFarland".

Patrick E. McFarland  
Inspector General



United States  
Office of Personnel Management  
**OFFICE of the 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



United States  
Office of Personnel Management  
**OFFICE of the INSPECTOR GENERAL**



# 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 257 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).

**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 20 final audit reports on organizations participating in the FEHBP, of which 10 contain recommendations for monetary adjustments in the amount of \$39.6 million due the OPM administered trust funds.

## COMMUNITY-RATED PLANS

The community-rated carrier audit universe covers approximately 136 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable Federal laws and regulations.

Federal regulations require that the FEHBP rates be equivalent to the rates a plan charges the two employer groups closest in subscriber size, commonly referred to as **similarly sized subscriber groups (SSSGs)**. The rates are set by the plan, which is also responsible for selecting the 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 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 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.

Starting in 2011, the Affordable Care Act (ACA) requires each large group health insurer to spend at least 85% of collected health insurance premiums on clinical services and quality improvement each year or provide a rebate. This is often explained as a 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% 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 12 final audit reports on community-rated plans and recommended approximately \$3.4 million in premium recoveries to the FEHBP. A report summary is provided below to highlight notable audit findings.

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## Blue Choice

ROCHESTER, NEW YORK

### Report No. 1C-MK-00-13-052

MAY 7, 2014

Blue Choice (Plan) has participated in the FEHBP since 1989, and provides health benefits to FEHBP members in the New York counties of Monroe, Livingston, Wayne, Ontario, Seneca, and Yates. The audit covered contract years 2010 through 2013. During this period, the FEHBP paid the Plan approximately \$91 million in premiums.

In 2010 through 2012, we identified inappropriate health benefit charges to the FEHBP totaling \$2,053,231. In addition, we determined the FEHBP is due \$90,303 for lost investment income as a result of the overcharges.



Inappropriate  
Charges  
Amount to Over  
\$2 Million

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 because there were discrepancies in the FEHBP's rate development in contract years 2011 and 2012. In addition, the Plan did not apply the largest SSSG discount to the FEHBP rates in contract years 2010 and 2011. The Plan agreed with our findings and returned the full amount questioned.

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**AUDIT ACTIVITIES**



## 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 \$12.9 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 maintaining an accounting of 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 63 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 \$12.9 million in questionable costs charged to the FEHBP contract. BCBS agreed with \$8.3 million of the identified overcharges. Summaries of four final reports are provided below and on pages 10 through 12 to highlight our notable audit findings.

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### Highmark Inc.

CAMP HILL, PENNSYLVANIA

**Report No. 1A-10-13-14-003**

AUGUST 22, 2014

Our audit of the FEHBP operations at Highmark Inc. (Plan) covered miscellaneous health benefit payments and credits from 2008 through May 2013 and administrative expenses from 2008 through 2012. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2008 through May 2013 and the Plan's Fraud and Abuse Program from 2008 through August 2013. For contract years 2008 through 2012, the Plan processed approximately \$1.8 billion in FEHBP health benefit payments and charged the FEHBP \$127 million in administrative expenses.



Our auditors questioned \$8,672 in administrative expense overcharges and applicable lost investment income (LII); and identified a procedural finding regarding the Plan's Fraud and Abuse Program.

Regarding the procedural finding, 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 one fraud and abuse case and reported three cases late to OPM's OIG. The Plan's non-compliance may be due in part to:

- 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 OPM's OIG.

**Auditors  
Identify a  
Procedural Finding  
with Highmark Inc.'s  
Fraud and Abuse  
Program**

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

The Association and Plan agreed with the questioned administrative expense charges and applicable LII, but generally disagreed with the procedural finding regarding the Fraud and Abuse Program.

## 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.



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## Health Alliance HMO

URBANA, ILLINOIS

**Report No. 1D-FX-00-14-001**

MAY 5, 2014

Health Alliance HMO (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 Illinois, Western Indiana, and Central and Eastern Iowa.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, such as refunds and pharmacy drug rebates, and cash management activities from 2008 through June 2013. In addition, we reviewed the Plan's Fraud and Abuse Program from 2012 through June 2013. For contract years 2008 through 2012, the Plan processed approximately \$144.4 million in FEHBP health benefit payments.

Our auditors identified no significant findings pertaining to miscellaneous health benefit payments and credits, the Plan's cash management activities and practices, and the Plan's Fraud and Abuse Program.

Overall, we concluded that the Plan

returned health benefit refunds and recoveries, including pharmacy drug rebates, to the FEHBP in a timely manner, and properly charged miscellaneous payments to the FEHBP.

We also concluded that the Plan handled FEHBP funds

in accordance with the FEHBP contract and applicable laws and

regulations. In addition, we determined that the Plan is complying with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters.



### Health Alliance HMO in Compliance With FEHBP Contract



# 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, our auditors evaluate historical health benefit claims data for appropriateness, and make 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 the audit reports issued during this period are provided below.

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## Information Technology Security Controls for OPM's Services Online System

WASHINGTON, D.C.

**Report No. 4A-RI-00-14-018**

APRIL 3, 2014

The Services Online (SOL) system is one of OPM's critical IT applications. As such we evaluated the system's compliance with the Federal Information Security Management Act of 2002 (FISMA). The SOL system is a web-based self-service information system for annuitants and survivor annuitants. Authorized SOL users can use this web site to start, change, or stop their Federal and State income tax withholdings; change their mailing address; sign up for or change their account or financial institution for direct deposit of their annuity payment; create checking or savings allotments; and view a monthly statement of their annuity. SOL is owned by OPM's Retirement Services program office.

Our objective was to perform an evaluation of the security controls for SOL to ensure that Retirement Services officials have managed the implementation of IT security policies and procedures in accordance with standards established by FISMA. We also independently tested approximately 30 specific information system security controls required by the National Institute of Standards and Technology's

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**AUDIT ACTIVITIES**



## Recommended Security Controls for Federal Information Systems and Organizations.

We did not detect any instances of non-compliance with regards to the major categories of FISMA requirements reviewed. Furthermore, we determined that all of the tested security controls were adequately implemented for SOL. Therefore, this audit report contained no findings or recommendations.

**No Instances  
of Non-Compliance  
Detected in OPM's  
Services Online  
System**

OPM has approximately 47 major information systems. Approximately one-third of these major systems, to include SOL, have an assigned dedicated Information System Security Officer (ISSO) to oversee their security controls. In accordance with our previous FISMA audit recommendations, OPM's Chief Information Officer (CIO) created the ISSO positions to facilitate a centralized approach to managing the security of OPM's various information systems. We believe that the strong security controls detected during this audit indicate that the ISSO-centric approach to managing information system security is effective. However, many OPM systems do not have a designated ISSO, and we strongly recommend that OPM's CIO continue efforts to hire additional ISSOs.

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### **Information Technology Security Controls for OPM's Investigations, Tracking, Assigning and Expediting System**

WASHINGTON, D.C.

**Report No. 4A-IS-00-14-017**

APRIL 3, 2014

The Investigations, Tracking, Assigning and Expediting (iTRAX) system is one of OPM's critical IT applications. As such, we evaluated the system's compliance with FISMA. The iTRAX application is designed to support

delivery of services to the Federal Investigative Service (FIS), which is responsible for delivery of investigative products and services that ensure Federal agencies have the data to base determinations of eligibility for a security clearance or employment in sensitive positions. The system is operated and hosted by an OPM contractor, CACI, on behalf of FIS.

Our objective was to perform an evaluation of the security controls for iTRAX to ensure that FIS officials have managed the implementation of IT security policies and procedures established by FISMA. We did not detect any instances of non-compliance with regards to the major categories of FISMA requirements reviewed, including: security assessment and authorization; security categorization; system security plan; security assessments and reports; contingency planning; privacy impact assessment; and plan of action and milestones.

As part of this audit, we also performed an independent test of approximately 55 specific security controls of the iTRAX system. While the system passed the vast majority of these tests, we did identify several instances where FIS could improve the security controls of the system.

FIS agreed with our recommendations and is taking the steps needed to address our concerns listed below:

### ***Segregation of Duties***

During interviews with subject matter experts we were told that CACI application developers have access to the iTRAX production environment and have administrator privileges within the back-end software platform. This situation constitutes a segregation of duties violation.

### ***Unsuccessful Login Attempts***

iTRAX servers and user workstations are not configured to comply with OPM policy because locked-out accounts automatically unlock after 15 minutes. OPM policy requires that "the information system automatically locks the account until released by an administrator when the maximum number of unsuccessful attempts is exceeded."



## Auditing Administrator Activity

iTRAX servers are configured to record the activity of system administrators. However, the logs generated by these servers are only reviewed retroactively if a problem has been reported or detected. There is no process in place to routinely review privileged user activity logs.

OPM  
Taking Steps  
to Address FISMA  
Non-Compliance  
Issues with  
iTRAX

## Physical and Environmental Protection

Although the current employees at CACI facilities have an informal understanding of their roles and responsibilities when responding to an emergency, there are no formally documented emergency response procedures.

## Information System General and Application Controls at the National Association of Letter Carriers Health Benefit Plan

ASHBURN, VIRGINIA

Report No. 1B-32-00-13-037

MAY 6, 2014

Our audit focused on the claims processing applications used to adjudicate Federal Employees Health Benefits Program (FEHBP) claims for the National Association of Letter Carriers Health Benefit Plan (NALC or Plan), as well as the various processes and information technology (IT) systems used to support these applications.

During the field work phase of this audit, we issued a flash audit alert to OPM's Director to bring immediate attention to serious concerns we had regarding the Plan's ability to adequately secure sensitive Federal data. The alert included two recommendations related to a lack of IT policies and inadequate management of system software configuration that we believed were urgent in nature, and advised the Plan to begin immediately taking steps to address the weaknesses.

We documented additional controls in place and opportunities for improvement in each of the areas below.

## Security Management

NALC has not developed an adequate security management program. The Plan has not developed IT security policies and procedures; implemented a formal security awareness training program or a specialized security training program; and has not established a formal risk management program.

## Access Controls

The Plan lacks adequate physical access controls surrounding its facilities and data center. Additionally, we documented several opportunities for improvement related to NALC's logical access controls related to password policy, segregation of duties, and monitoring user accounts.

## Network Security

Our review of the network security controls indicated that the Plan has implemented and utilizes a firewall to protect its network environment. However, we noted several areas of concern:

- Vulnerability scan results indicate that critical patches, service packs, and hot fixes are not implemented in a timely manner; and
- The Plan does not have controls to detect and prevent unauthorized devices from connecting to the internal network.

## Configuration Management

**Baseline Configuration** – A baseline configuration is a policy that outlines how the security setting of each of the platforms should be configured. Once this initial configuration is established, organizations should audit the "actual or current" setting of the operating platforms against the previously approved baseline to ensure no deviations exist.

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**AUDIT ACTIVITIES**



Our audit revealed three configuration management findings.

- NALC has not documented formal baseline configurations for all of the operating systems it uses and, as a result, the Plan is unable to routinely audit its network servers' configuration to any approved configuration settings;
- The Plan has also not established a formal systems development lifecycle methodology; and,
- Although NALC has documented corporate password standards, we discovered many instances where information systems did not follow the established guidelines.

### Contingency Planning

NALC has not conducted an adequate business impact analysis. Currently, NALC does not have an alternate location to recover its computing environment in the event of a disaster at its primary data center. Also, NALC has not established an alternate work site for its employees to allow for critical business operations to continue if the main facility is not accessible. The backup power generator at the NALC facility does not have the capacity to sustain the data center in the event of a prolonged power outage. NALC's contingency plan does not address many of the suggested contingency guidance elements; and the plan is not routinely tested.

Auditors  
Question NALC's  
Ability to Protect  
Sensitive Federal  
Data

### Claims Adjudication

NALC has implemented many controls in its claims process to ensure that FEHBP claims are processed accurately with regard to enrollment and debarment. However, we noted significant weaknesses in the information system used by the Plan to adjudicate health benefit claims because it:

- Could not adequately detect claims with medical inconsistencies;
- Incorrectly followed American Medical Association billing guidelines;

- Could not adequately detect duplicate room and board charges for hospital claims; and
- Could not detect multiple claims for a procedure that can only be performed once.

### Health Insurance Portability and Accountability Act (HIPAA)

NALC has developed a series of privacy policies and procedures that address requirements of the HIPAA privacy rule. However, some elements of the HIPAA security rule remain to be implemented, creating information technology security weaknesses.

### Information Technology Security Controls for OPM's Development Test Production General Support System

WASHINGTON, D.C.

Report No. 4A-CI-00-14-015

JUNE 6, 2014

OPM's Development Test Production General Support System (DTP) represents a critical OPM IT application; therefore our auditors evaluated the system's compliance with FISMA.

The DTP environment is a general support system owned and operated by the Office of the Chief Information Officer (OCIO) that was designed to be a separate technical environment from OPM's Local Area Network/Wide Area Network (LAN/WAN) production environment. DTP is intended to host the testing and development of applications, while LAN/WAN is designed to host production applications. However, the production environment of DTP resides on the LAN/WAN and is not segregated from the production applications hosted on LAN/WAN resulting in two production environments. While there are clearly defined technical boundaries segregating the two environments within DTP, there should only be one production environment in OPM's infrastructure.

DTP is currently classified as a "major application" and is included on OPM's master inventory of major systems. During the course of the audit we were informed that it is the intention of the OCIO to reclassify the development and test elements of DTP as subsystems under the LAN/WAN, and to



consolidate the production elements of DTP into the LAN/WAN production environment.

Although reclassifying DTP as a minor application would alleviate some of the FISMA requirements applicable to major systems, it does not absolve the OCIO from ensuring the remediation of the security weaknesses identified in prior security assessments and this audit report.

**OPM Maintains Multiple Technical Environments Which Lack Adequate Segregation**

As part of this audit we also determined that the OCIO could improve the security controls of DTP related to configuration change control. DTP application programmers have the technical ability to develop a change and move it into production without following the appropriate change control process. No one individual should have access to independently migrate a change through the entire change control environment without prior approval.

## **Information System General and Application Controls at BlueShield of California**

SAN FRANCISCO, CALIFORNIA

**Report No. 1A-10-67-14-006**

JULY 9, 2014

BlueShield of California (BSC) has two separate plans that service Federal employees: a Health Maintenance Organization (HMO) plan referred to as Access+ HMO, and a nationwide fee-for-service plan sponsored by the BlueCross and BlueShield Association (BCBSA) FEP. We reviewed the information systems used to process the BCBSA's claims, as well as the various business processes and IT systems used to support these applications.

We documented additional controls in place and opportunities for improvement in each of the areas below.

### **Security Management**

Nothing came to our attention to indicate that BSC does not have an adequate security management program.

### **Access Controls**

BSC has implemented numerous controls to grant and remove physical access to its data center, as well as logical controls to protect sensitive information. All weaknesses identified during the audit were remediated during the draft reporting period.

### **Network Security**

BSC has implemented a thorough incident response and network security program. However, we noted several areas of concern with BSC's network security controls related to vulnerability management, firewall management, and auditing privileged user accounts.

### **Configuration Management**

BSC has developed formal policies and procedures that provide guidance to ensure that system software is appropriately configured, updated, and changes are controlled. However, BSC has not documented formal baseline configurations that detail the approved settings for its server operating systems, and therefore cannot effectively audit its security configuration settings.

### **Contingency Planning**

BSC's business continuity and disaster recovery plans contained the key elements suggested by relevant guidance and publications.

### **Claims Adjudication**

BSC has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we noted several weaknesses in BSC's claims application controls related to medical editing, detecting duplicate claims, and enforcing American Medical Association billing guidelines.

**Blue Shield of California Possesses an Adequate Security Management Program, Opportunities for Enhancement Recommended**

APRIL 1, 2014 – SEPTEMBER 30, 2014

**AUDIT ACTIVITIES**



## **Health Insurance Portability and Accountability ACT (HIPAA)**

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

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### **Information Technology Security Controls for OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems**

WASHINGTON, D.C.

**Report No. 4A-RI-00-14-036**

AUGUST 19, 2014

BENEFEDS and the Federal Long Term Care Insurance Program (FLTCIP) information systems are two of OPM's major applications subject to FISMA requirements. The BENEFEDS and FLTCIP systems are both owned by OPM's Healthcare and Insurance Office (HI) and operated by a contractor, the Long Term Care Partners (LTCP) organization. The systems operate independently, but share many operational and security controls. Therefore, our audit findings are combined into one report.

Although both systems are generally compliant with FISMA requirements, we did identify several specific security weaknesses with these systems.

#### **Separation of Duties**

LTCP does not maintain a documented policy or security matrix to outline the required segregation of duties related to the user roles in the BENEFEDS and FLTCIP systems.

#### **Configuration Management**

LTCP has not documented baseline configurations for server operating systems, and therefore cannot effectively audit security settings (i.e., there are no approved settings to which to compare the actual settings).

## **Physical Access Controls**

The physical access controls in LTCP's data center could be improved by enforcing multi-factor authentication and implementing technical or physical controls to detect or prevent piggybacking (i.e., multiple people entering after a single person unlocks the door).

#### **Boundary Protection**

LTCP has implemented firewalls to help secure its network environment. However, a firewall hardening policy has not been developed, and there is no routine review of the firewall configuration.

**IT Security Weaknesses Identified in BENEFEDS and the Federal Long Term Care Insurance Program**

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### **Supplemental Global Audit on Non-Covered Ambulance Claims for BlueCross and BlueShield Plans**

WASHINGTON, D.C.

**Report No. 1A-99-00-143-046**

APRIL 7, 2014

We performed a limited scope performance audit to determine whether BlueCross and BlueShield (BCBS) plans paid claims that potentially contained non-covered ambulance services. The audit report covers health benefit payments from June 1, 2011 through December 31, 2012, and supplements our fiscal year 2012 Global Coordination of Benefits

Audit (Report No. 1A-99-00-12-029)

where we identified issues related to the processing of claims for ambulance services.

**BCBS  
Erroneously Paid  
\$1.4 Million in  
Ambulance  
Claims**

Specifically, we requested the BlueCross BlueShield Association to identify all BCBS claims potentially containing non-covered ambulance services

during the reporting period. Our review determined that 7,548 claims, totaling \$1,423,823 in health benefit charges, were erroneously paid.



## Claims Audit at BlueCross BlueShield of Tennessee

CHATTANOOGA, TENNESSEE

Report No. 1A-10-14-13-058

JUNE 6, 2014

Our audit of claim payments made by BlueCross BlueShield of Tennessee (BCBST or Plan) questions \$3,618,301 in health benefit charges from January 1, 2010 through March 31, 2013. The questioned charges are summarized below.

### ***Retroactive Enrollment***

The Plan did not initiate and/or complete the recovery process for payment errors related to 4,928 claims that were paid before the member's eligibility status was updated, resulting in overcharges of \$1,949,774 to the FEHBP.

### ***Place of Service Review***

Our review of a judgmental sample of claims paid by the Plan's local system determined that 1,088 claims were paid incorrectly, resulting in net overcharges of \$1,628,666 to the FEHBP.

**Auditors  
Question BCBST  
with \$3.6 Million  
in Claims Benefit  
Overcharges**

### ***Modifiers***

The Plan incorrectly paid 62 claim lines containing procedure code modifiers, resulting in overcharges of \$20,825 to the FEHBP.

### ***Omnibus Budget Reconciliation Act (OBRA) 90***

The Plan incorrectly paid 16 OBRA 90 claims, resulting in net overcharges of \$15,366 to the FEHBP.

BCBST agreed with \$937,069 of these questioned overcharges, disagreed with \$1,856,362, and did not respond to \$824,870. The majority of the charges contested by the Plan relate to a criminal case currently in litigation, and BCBST has not provided us with evidence supporting the medical necessity and appropriateness of these claim payments.

## Global Audit of Duplicate Claim Payments for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-13-061

AUGUST 19, 2014

We performed a limited scope performance audit to identify duplicate health benefit claim payments made by BlueCross and Blue Shield (BCBS) plans during the period from January 1, 2011 through May 31, 2013.

Using various search criteria, we identified and reviewed claims paid from January 1, 2011 through May 31, 2013 for potential duplicate payments charged to the FEHBP. Based on our review, we determined that the BCBS plans improperly charged the FEHBP for 9,544 claim payments, resulting in overcharges of \$7,878,473 to the FEHBP.

**Audit  
Identifies  
\$7.8 Million in  
BCBS Duplicate  
Claim  
Overcharges**

We continue to identify significant claim overcharges to the FEHBP on our global duplicate claim payment audits. These claim payment errors could be significantly reduced if the BlueCross BlueShield Association and/or BCBS plans implement the procedural recommendations provided to enhance its information system so that it can detect duplicate claims before they are paid.

APRIL 1, 2014 – SEPTEMBER 30, 2014

**AUDIT ACTIVITIES**



# 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.*

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## OPM's Fiscal Year 2013 Improper Payments Reporting

WASHINGTON, D.C.

Report No. 4A-CF-00-14-009

APRIL 10, 2014

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. On July 22, 2010, the 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 Office of Management and Budget (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 for the most recent fiscal year and post the report, and any accompanying materials required by OMB, on the agency's website;
- Conduct program specific risk assessments of all programs and activities to identify those that are susceptible to significant improper payments;
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment in the AFR;

- Publish programmatic corrective action plans in the AFR;
- Publish and meet annual reduction targets for each program assessed to be at risk for improper payments;
- Report a gross improper payment rate of less than ten percent for each program or activity for which an improper payment estimate was obtained and published in the AFR; and,
- Report information on its efforts to recapture improper payments.

We conducted a performance audit of OPM's Fiscal Year (FY) 2013 Improper Payments Reporting for compliance with IPERA. Our

**OPM  
Complies with  
IPERA Guidance,  
Recommendations  
for Improvement  
Cited**

objective was to determine if OPM's improper payments reporting in the 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 (RS) and Healthcare and Insurance programs.

We found that OPM was in compliance with IPERA for FY 2013 improper payments reporting. However, we identified one area of improvement concerning OPM's internal controls over improper payments reporting. During our review, several variances between the improper payments data reported in OPM's AFR and the support used to validate the data were identified.



As a result, we recommended that OPM strengthen its oversight controls over improper payments data reported in the AFR to ensure that it accurately reflects supporting documentation. OPM agreed with our finding.

We also determined that our recommendation from the FY 2012 IPERA audit, to include a description of the methods used to recapture improper payments in the AFR, was resolved.

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## **Federal Investigative Services' Case Review Process Over Background Investigations**

WASHINGTON, D.C.

**Report No. 4A-IS-00-13-062**

JUNE 4, 2014

We conducted a performance audit of the Federal Investigative Services' (FIS) Case Review Process over Background Investigations. Our audit objectives were to determine if:

- FIS has adequate oversight controls in place to ensure that US Investigations Services (USIS), CACI International Inc. (CACI), and KeyPoint Governmental Solutions, Inc. (KGS), hereafter referred to as the "Contractors," are meeting their contract requirements;
- the Contractors' background review process meets its contract requirements;
- FIS has controls in place to ensure the Federally-conducted background investigations are reviewed; and
- FIS and its Contractors have controls in place to ensure that their review personnel are properly trained to perform their duties.

FIS is responsible for conducting background investigations on Federal applicants, employees, and contractor personnel for customer agencies on a reimbursable basis to determine the eligibility of these individuals to hold security clearances or to be employed in positions with national security

sensitivity, eligibility for accession or retention in the Armed Forces, eligibility for an identity credential, or suitability or fitness for employment for or on behalf of the Government. During fiscal year 2013 FIS contracted with USIS, CACI, and KGS to assist with completing background investigations. FIS also had an additional contract with USIS to provide support services.

Each Contractor is required to have a process in place to conduct a 100 percent pre-submission quality review of all investigative work products to ensure compliance with contract requirements and national investigative and adjudicative standards. Once a Report of Investigation (ROI) is marked "Ready to Review" in the Personnel Investigation Processing System (PIPS), the reviewer can conduct their review. The Contractors' reviewers are responsible for reviewing all ROIs in PIPS. Once the review is completed, the ROI's status should be updated to "Review Complete" by the reviewer. FIS utilizes the lack of the events listed below in PIPS-Reporting as indicators of potential fraud or non-compliance with contract requirements since these PIPS-Reporting functions should occur before the "Review Complete" event.

- Display – ROI opened in PIPS;
- Modify – Minor edits made to the ROI; and,
- Print – ROI printed for review.

**Recommend  
OPM Strengthen  
Controls Over  
Contractors and  
the Background  
Investigations Review  
Process**

An exception to this process occurs when ROIs are auto-released. After 30 days, PIPS will auto-release the ROI and mark it "Review Complete"; thereafter, the Contractors can only display, modify, or print the ROIs.

Our auditors interviewed FIS and the Contractors' employees; performed analytical testing; sampled background investigations and reviewed internal documents; and reviewed training documentation.

APRIL 1, 2014 – SEPTEMBER 30, 2014

**AUDIT ACTIVITIES**



We determined that OPM needs to strengthen its controls over its Contractors and the background investigation review process.

Specifically, we found the following concerns:

- We identified two areas of improvement that could have a positive impact on the background review process. The areas include:
  - The PIPS event indicators (Display, Modify, and Print) are weak controls to ensure all investigative items have been reviewed.
  - FIS does not have a control in place to verify that the Contractors are conducting a review on auto-released ROIs. Auto-release is a process that FIS has designed in PIPS to ensure ROIs do not sit idle in the Contractor's queue for a substantial period of time. The contract reviewer has 30 days from the "Ready to Review" date to review the ROI. After 30 days, auto-release activates and marks the ROI "Review Complete" and the Contractors can only display, modify, or print the ROIs. A review of auto-released ROIs should be conducted by a reviewer prior to submission to FIS, even though they are marked "Review Complete" in PIPS.
- Two USIS reviewers completed an abnormally high number of reviews on background investigations in a short timeframe. For example, one of the reviewers completed 15,152 background investigations reviews in one month, with most of these occurring within minutes of each other on multiple days.
- We identified 17 out of 328 ROIs which were not reviewed by USIS, CACI, and KGS prior to submitting them to OPM.
- USIS and KGS were unable to provide support to show that 29 out of 100 reviewers and support personnel we reviewed met training requirements. Twenty-four of the 29 lacking training documentation were USIS employees.



# Special Audits

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

During this reporting period we issued two final audit reports, which are summarized below.

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## **Federal Employees' Group Life Insurance Program as Administered by the Metropolitan Life Insurance Company**

ORISKANY, NY AND BRIDGEWATER, NJ

**Report No. 2A-II-00-13-065**

JULY 9, 2014

We conducted an audit of the Federal Employees' Group Life Insurance Program's (FEGLI) operations for contract years 2009 through 2012. The audit's primary objective was to determine whether the Metropolitan Life Insurance Company's (MetLife) costs charged and services provided to FEGLI subscribers were in accordance with the terms of the contract and applicable Federal regulations.

The FEGLI Program was created in 1954 by the Federal Employees' Group Life Insurance Act (Public Law 83-598). OPM's Healthcare and Insurance Office (HIO) has overall responsibility for administering the

FEGLI Program, including the publication of program regulations and agency guidelines; and the receipt, payment, and investment of agency withholdings and contributions. The HIO contracts with MetLife to provide life insurance coverage to Federal employees, annuitants, and their family members. Employer agencies are responsible for enrolling, informing and advising active employees of program changes; determining eligibility; maintaining insurance records; withholding premiums from pay; remitting and reporting withholdings to OPM; and certifying salary and insurance coverage upon separation or death.

MetLife's responsibilities under the contract are carried out by the Office of Federal Employees' Group Life Insurance (OFEGLI), an administrative unit of MetLife established to administer the FEGLI Program. OFEGLI is located in Oriskany, New York, and MetLife provides support activities to OFEGLI through its offices in Bridgewater, New Jersey, and Long Island City, New York. OFEGLI's responsibilities include:

- Processing and paying claims;
- Determining whether an insured individual is eligible for a living benefit;
- Determining whether accidental death and dismemberment benefits are payable;

APRIL 1, 2014 – SEPTEMBER 30, 2014

**AUDIT ACTIVITIES**

- Determining an employee's eligibility to cancel a waiver of insurance based on satisfactory medical information; and
- Processing requests for conversions from group to individual policies.

The audit identified four instances of non-compliance with the contract or program regulations and questioned \$1,210,293 in unallowable charges, including \$43,723 in lost investment income. The audit also identified one area for program improvement. Specifically we identified:

- \$931,903 in excess funds from contract year 2011 that were identified as being owed to the FEGLI Program but were not returned.
- An overcharge of \$144,667 in contract year 2009 that resulted from MetLife's use of an incorrect allocation rate in its charging of indirect administrative expenses to the FEGLI Program.
- An overcharge of \$90,000 in contract year 2012 that resulted from MetLife exceeding its indirect cost limit.

- \$43,723 in lost investment income due to the FEGLI Program on questioned administrative expense overcharges.

- One program improvement area related to

MetLife's accounting for travel

expenses. While this area was not a violation of the FEGLI contract and applicable Federal regulations, we recommend that MetLife implement accounting procedures to ensure that travel expenses for lodging, meals, and incidentals charged to the FEGLI Program are reasonable and allowable.

**\$1.2 Million  
in Unallowable  
Administrative  
Expenses Charged  
to the FEGLI  
Program**

MetLife agreed with all audit issues and continues to work with OPM to ensure our recommendations are implemented.





# Combined Federal Campaign

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

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

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

## LOCAL CFC AUDITS

The local organizational structure consists of:

### ■ **Local Federal Coordinating Committee (LFCC)**

The LFCC is a group of Federal officials designated by the Director of OPM to conduct the CFC in a particular community. It organizes the local CFC; determines the eligibility of local charities; selects and supervises the activities of the Principal Combined Fund Organization (PCFO); encourages Federal agencies to appoint employees to act as Loaned Executives who work directly on the local campaign; ensures that Federal employees are not coerced to participate in the local campaign; and resolves issues relating to a local charity's non-compliance with the CFC policies and procedures.

### ■ **Principal Combined Fund Organization**

The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. The primary goal of the PCFO is to administer an effective and efficient campaign in a fair and even-handed manner aimed at collecting the greatest amount of charitable contributions possible. Its responsibilities include collecting and distributing CFC funds, training volunteers, maintaining a detailed accounting of CFC administrative expenses incurred during the campaign, preparing pledge forms and charity lists, and submitting to and cooperating fully with audits of its operations. The PCFO is reimbursed for its administrative expenses from CFC funds.

### ■ **Federations**

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

### ■ **Independent Organizations**

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

Our continued concern is the consistent identification of similar issues from audit to audit. The causes for these issues are, more often than not, attributed to one of the following program concerns:

- The PCFO is either not aware of, or does not understand its responsibilities as defined in the regulations and CFC memoranda, or simply does not follow said regulations and memoranda;

- The LFCC is either not aware of or does not understand its responsibilities as defined in the regulations;
- The LFCC is inactive and does not perform the needed oversight of the PCFO; or
- The IPAs hired to perform the agreed-upon procedures audit are paid out of campaign funds and do not understand the requirements of the audit resulting in findings not being identified and communicated to the PCFOS and LFCCs.

It is for these reasons that the OIG supports the final CFC regulations published in April of 2014. We believe these new regulations will help eliminate many of the recurring findings we identify and will help to ensure that a larger percentage of the Federal employees' donations go towards their intended purposes.

During this reporting period, we issued one audit report of a local CFC that is discussed below.

## **Audit Report on the 2005 through 2012 Combined Federal Campaigns as Administered by the Metropolitan Arts Partnership**

SACRAMENTO, CA

**Report No. 3A-CF-00-13-051**

JULY 10, 2014

We conducted an audit of the Combined Federal Campaign as administered by the Metropolitan Arts Partnership (MAP) due to concerns raised from an IPA audit, at the request of OPM's OCFC. We expanded the scope of this audit to cover the 2005 through 2012 campaigns because of these significant concerns. Our audit identified the following issues:

### ■ **Administrative Expense Overcharges**

MAP charged the 2005 through 2012 CFCs \$1,899,465 in administrative expenses that exceeded expense amounts reported in its general ledger. Of this amount, \$770,216 was comprised of unallowable costs that exceeded 110 percent of the approved campaign budgets;

### ■ **2011 Campaign Expenses**

MAP charged the 2011 campaign \$101,811 in expenses that were unsupported, unallowable, or improperly allocated;

### ■ **Outstanding Check Procedures**

MAP's policies and procedures for outstanding checks did not adhere to the OCFC's requirements. In addition, MAP has not issued or redistributed \$7,653 in outstanding checks related to prior campaigns;

### ■ **Pledge Form Errors**

Our review identified 12 pledge forms with a total of 7 errors, one of which resulted in a charity not receiving a disbursement of \$2,600; and

**Over \$2 Million  
in Unallowable  
Administrative  
Expenses Charged  
to the CFC**

### ■ **CFC Funds Not Maintained in Interest- Bearing Accounts**

MAP did not maintain CFC funds in an interest-bearing account during its administration of the 2005 through 2012 campaigns.

*The overcharges identified on this audit were the largest amounts ever questioned on a CFC audit.* Factors contributing to the audit issues identified above were MAP's lack of familiarity with the CFC regulations, its lack of business and accounting policies and procedures, and its failure to maintain formal records of actions or approvals of CFC matters. As a result of the extreme carelessness demonstrated by MAP in its administration of the campaign, we strongly suggested to OPM's OCFC that it not be considered as the PCFO for any future campaigns.







# ENFORCEMENT ACTIVITIES

## Investigative Cases

*The Office of Personnel Management administers benefits from its trust funds, with approximately \$955 billion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$128 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 office opened 30 criminal investigations and closed 31, with 97 still in progress. Our criminal investigations led to 29 arrests, 41 indictments and informations, 30 convictions and \$4,199,535 in monetary recoveries to OPM-administered trust funds. Our criminal investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$85,414 in criminal fines and penalties, which are returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a complete statistical summary of our office's investigative activity, refer to the table on page 44.

## 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, 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.

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

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### **Pharmaceutical Company Agrees to Pay \$56.5 Million to Resolve False Claims Allegations**

In September 2014, a pharmaceutical company, Shire Pharmaceuticals LLC (Shire), agreed to pay \$56.5 million to resolve civil allegations that it violated the False Claims Act as a result of its marketing and promotion of several drugs. Shire, located in Wayne, Pennsylvania, manufactures and sells pharmaceuticals, including Adderall XR, Vyvanse, and Daytrana, which are approved for the treatment of attention deficit hyperactivity disorder (ADHD); and Pentasa and Lialda, which are approved for the treatment of mild to moderate active ulcerative colitis.

The settlement resolves allegations that, between January 2004 and December 2007, Shire promoted Adderall XR for certain uses despite the lack of clinical data to support such claims and overstated the efficacy of Adderall XR, particularly relative to other ADHD drugs. Among the allegedly unsupported claims were that Adderall XR was clinically superior to other ADHD drugs because it would “normalize” its recipients, rendering them indistinguishable from their non-ADHD peers. Shire allegedly stated that its competitors’ products could not achieve similar results, which the Government contended was not shown in the clinical data that Shire collected. Shire also allegedly marketed Adderall XR based on unsupported claims that it would prevent poor academic performance, loss of employment, criminal behavior, traffic accidents and sexually transmitted diseases. In addition, Shire allegedly promoted Adderall XR for the treatment of conduct disorder without approval from the Food and Drug Administration (FDA).

The settlement further resolves allegations that, between February 2007 and September 2010, Shire sales representatives and other agents allegedly made false and misleading statements about the effectiveness and risk of abuse of Vyvanse to state Medicaid formulary committees and physicians. For example, one Shire medical science liaison allegedly told a state formulary board that Vyvanse “provides less abuse liability” than “every other

long-acting release mechanism” on the market. However, the Government contended that no study Shire conducted had concluded that Vyvanse was less likely to be abused. Furthermore, as an amphetamine product, the Vyvanse label included an FDA-mandated black box warning for its potential for misuse and abuse. Shire also made allegedly unsupported claims that treatment with Vyvanse would prevent car accidents, divorce, arrests and unemployment.

Additionally, the settlement resolves allegations that from April 2006 to September 2010, Shire representatives improperly marketed Daytrana, administered through a patch, as less prone to abuse than traditional, pill-based medications. For a portion of this period, Shire representatives improperly made phone calls and drafted letters to state Medicaid authorities to assist physicians with the prior authorization process for prescriptions to induce these physicians to prescribe Daytrana and Vyvanse.

The case was ultimately settled resolving allegations that between January 2006 and June 2010, Shire sales representatives promoted Lialda and Pentasa for off-label uses not approved by the FDA and therefore not covered by Federal healthcare programs. The Government also alleged that Shire promoted Lialda off-label for the prevention of colorectal cancer.

As a result of the investigation, the FEHBP will receive approximately \$1.2 million.

This was a joint investigation by the Health and Human Services (HHS) OIG, the FDA and our office.

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### **Illinois Company Agrees to Pay \$7.3 Million to Resolve Off-Label Marketing Allegations**

In April 2014, pharmaceutical company, Astellas Pharma US, Inc., located in Northbrook, Illinois, agreed to pay \$7.3 million to resolve allegations that it violated the False Claims Act in connection with its marketing promotion of the drug, Mycamine, for pediatric use.



The settlement resolves allegations that between 2005 and 2010, Astellas knowingly marketed and promoted the sale of Mycamine for pediatric use, which was not approved and, therefore, not covered by Federal health care programs. During this time period, the FDA approved Mycamine to treat adult patients suffering from serious and invasive infections caused by the fungus Candida, including infections in the esophagus, the blood and the abdomen. The FDA also approved this drug to prevent Candida infections in adults undergoing stem cell transplants. However, from 2005 through June 2013, Mycamine was not approved to treat pediatric patients for any use.

As the result of the joint investigation with HHS OIG, the FEHBP trust fund will receive \$202,976.

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### **Non-Profit Catholic Health Care System Agrees to Settle Civil Allegations that its Hospitals Improperly Billed Government Health Programs**

In July 2014, a non-profit Catholic health system, Carondelet Health Network (Carondelet), agreed to pay \$35 million to settle civil allegations that its hospitals improperly billed the Government for inpatient rehabilitation services. Carondelet operates two hospitals in Tucson, Arizona: St. Mary's Hospital and Carondelet St. Joseph's Hospital.

The alleged improper billing of Medicare, the FEHBP, and the Arizona Health Care Cost Containment System (Arizona's Medicaid agency) occurred between April 7, 2004 and December 31, 2011. The allegation stated that Carondelet falsely billed Government Health Programs for inpatient rehabilitation facility services by failing to meet rehabilitation therapy time requirements and failing to perform other required services. (e.g., pre-admission screening, plan of care documentation, and team conference meeting documentation).

Prior to Carondelet becoming aware of the Government's investigation, Carondelet disclosed to the Government some inpatient rehabilitation overpayments and tendered a substantial repayment.

As a result of this settlement, investigated jointly by the HHS OIG and our office, the FEHBP received \$439,402 in restitution.

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### **Three Employees of a Hyperbaric Wound Care Treatment Facility Found Guilty of Double Billing, False Statements, and Money Laundering**

In August 2009, we received an allegation from the Federal Bureau of Investigation (FBI) related to a hyperbaric wound care treatment facility in Texas stating that facility employees knowingly and intentionally were billing for hyperbaric wound care treatments incorrectly.

In January 2011, a search warrant was executed at the residence of the owners of the facility. Documents and records obtained during the search warrant revealed possible conspiracy to commit health care fraud. Additional documents discovered led to the expansion of the investigation to include potential false statements to a financial institution, and money laundering charges.

On September 6, 2012, a grand jury in the Northern District of Texas issued an indictment against three defendants involved in the fraudulent activity. The three defendants were arrested on September 13, 2012. On July 30, 2013, two defendants pled guilty to one count of conspiracy to commit health care fraud and one defendant pled guilty to conspiracy to make a false statement to a financial institution.

On June 6, 2014, two of the defendants were sentenced to prison terms of 60 months and 24 months of supervised release. Total restitution in this case was ordered in the amount of \$1,503,442, a \$200 court assessment fee, and \$103,184 ordered to be paid back to the FEHBP.

This was a joint investigation conducted by the FBI, HHS OIG and our investigators.





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### **Owner of a Cancer Treatment Facility Pleads Guilty to Resolve False Claims Allegations**

Hope Cancer Institute (Institute) and its owner of the cancer treatment facility located in Kansas, have agreed to pay \$2.9 million to resolve allegations that they violated the False Claims Act by submitting claims to Medicare, Medicaid and the FEHBP for drugs and services that were not provided to patients.

The settlement resolves allegations that between 2007 and 2011, the owner and the Institute submitted claims to Federal health benefit programs for chemotherapy drugs: Rituxan, Avastin and Taxotere, which were not provided to Federal health care beneficiaries. The owner allegedly instructed the employees of the Institute to bill for a predetermined amount of chemotherapy medications at certain dosage levels, when lower dosages of these drugs were actually provided to patients. As a result of these instructions, Hope Cancer Institute submitted inflated claims to Federal health care programs.

The settlement returns \$124,215 back to the FEHBP as a result of the joint investigation performed by HHS OIG and our office.

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### **Kansas Doctor Pleads Guilty to One Count of Conspiracy to Distribute Controlled Substances**

This case was opened in January 2013 after discussions with Assistant United States Attorney from the U.S. Attorney's Office in Topeka, Kansas regarding a doctor and a non-licensed health care worker's illegal prescribing practices.

On January 16, 2014, the doctor from Kansas pled guilty to one count of conspiracy to distribute prescription controlled substances, between April 2007 and August 2012. To carry out daily operations at his clinic, the doctor employed up to 12 office staff members, none of whom had lawful authority to distribute controlled substances. He directed and allowed staff members to distribute controlled substances to his patients using blank prescription pads containing his signature which he prepared in advance.

On February 10, 2014, the non-licensed health care worker pled guilty to conspiracy to distribute prescription controlled substances.

On April 9, 2014, the doctor was sentenced to 60 months imprisonment followed by three years of supervised release. The physician was also ordered to pay a \$100 court assessment fee and \$100,772 in restitution to health care programs, with the FEHBP receiving \$6,363.

On April 28, 2014, the non-licensed health care worker was sentenced to 24 months supervised release and ordered to pay a \$100 court assessment fee.

This was a joint investigation by HHS OIG and our office.

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### **Vision Center Settles After Billing for Free Drug Samples**

In May 2014, a vision center entered into a settlement agreement with the Government to resolve allegations that it billed for free samples of drugs. The investigation revealed that from May 2011 through February 2013, the vision center obtained free samples of the drug Lucentis, through the Genentech Lucentis Sampling Program, and administered these samples to some of its patients, including those who were beneficiaries of Federal programs.

The vision center agreed to repay \$47,197 to the United States Government to resolve the allegation. As a result of this settlement, the FEHBP recovered \$2,497.

This was a joint investigation conducted by the HHS OIG and our investigators.

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### **Non-Profit Hospice Care Center Agrees to Pay \$80,779 to Resolve False Claims Allegations**

A non-profit hospice care center entered into a settlement agreement with the Government to resolve allegations of miscoding for hospice and palliative care services.

***Palliative care is an approach to care that improves the quality of life of patients and their families facing the problems associated with life-threatening illnesses.***

The group agreed to pay \$80,779 to resolve Federal False Claims Act allegations of miscoding of hospice and palliative care services billed through a salaried physician. The physician was alleged to have miscoded initial patient visits using evaluation and management codes that did not support or warrant their use, providing unjust enrichment to the company.

The FEHBP recovered \$4,494 as part this settlement. This case was investigated by the FBI, the Defense Criminal Investigative Service (DCIS), HHS OIG, and our office.

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### **Bostwick Laboratories, Inc. Agrees to Pay \$1.1 Million to Resolve False Claims Act Allegations**

The case originated as a *qui tam* complaint filed in the Eastern District of Virginia alleging Bostwick Laboratories, Inc. (Bostwick) erroneously billed Federal health programs for pathology testing.

***A Qui tam is an action brought by an informer, under a statute which establishes a penalty for the commission or omission of a certain act, and provides that the same shall be recoverable in a civil action, part of the penalty to go to any person who will bring such action and the remainder to the state or some other institution.***

Bostwick operates laboratory facilities in New York, Virginia, Florida, and Texas. Bostwick performs anatomic and clinical pathology services specializing in the monitoring and diagnosis of cancer.

When a pathologist notices an abnormal cell architecture or appearance, the lab performs a second level of testing in which the tissue is saturated with various protein molecule antibodies. The complaint alleged that the lab would charge for each protein antibody separately rather than charging for the 'cocktail' of required antibodies eliminating the laboratories' need to perform a separate stain for each antibody.

On August 28, 2014, Bostwick entered into a settlement agreement with the DOJ to resolve the allegations and agreed to pay \$1,152,000. As a result of the settlement, the FEHBP will receive approximately \$144,292.

This joint investigation was performed by the HHS OIG and our investigators.

## **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

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### **Daughter Steals Deceased Survivor Annuitant's Benefit Payments**

We initiated this investigation in July 2012 after receiving an allegation that a Federal survivor annuitant had died and her daughter continued to cash her mother's benefit payments.

Our investigation confirmed that the survivor annuitant's daughter was illegally cashing the benefit checks at a money market store. The daughter was able to continue the fraudulent behavior because OPM was never notified of her mother's death and the store never asked for proper identification.

In March 2014, the daughter pled guilty to theft of public money. She was sentenced in July 2014 to six months imprisonment, serve three years of probation, pay a \$100 court assessment fee, and ordered to pay \$19,919 in restitution to OPM.

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### **Friend of Deceased Annuitant's Son Steals Annuity Payments**

Annuity payments continued for a deceased annuitant from her death on April 18, 2003 until June 30, 2014 because OPM was not notified of the annuitant's death. The investigation revealed that a non-family member had gained access to the annuitant's bank account through his friendship with the annuitant's son. Annuity payments to the son's friend also included social security payments.

On June 16, 2014, this individual was charged with theft of public funds with the total loss to the Government cited as \$385,632. On June 23, 2014, the defendant pled guilty to one count of embezzlement and theft of public money.

On September 10, 2014, the defendant was sentenced to 24 months in prison, two years of supervised release, pay a \$100 court assessment fee, and to pay restitution in the amount of \$373,815, of which \$218,820 is slated to be returned to OPM.

## 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 FIS conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts over 90 percent of all personnel background investigations for the Federal Government. With a staff of over 9,400 Federal and contract employees, FIS processed over 2.3 million background investigations in FY 2013. 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 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 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.

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### **Former OPM Contract Background Investigator Sentenced for Falsifying Numerous Background Investigations**

In August 2010, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM Contract (USIS) Background Investigator.

Between May 2009 and April 2010, in more than four dozen Reports of Investigations, the background investigator represented that he had interviewed a source or reviewed a record regarding the subject of a background investigation, when in fact he had not conducted the interview or obtained the record. These reports were utilized and relied upon by Federal agencies to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator, which cost \$173,446.

On April 24, 2014, the former background investigator pled guilty to making a false statement and on July 25, 2014 was sentenced to serve six months of home confinement, 36 months of probation, and 150 hours of community service. The former investigator was also ordered to pay a \$100 court assessment fee and full restitution of \$173,446 to OPM. In addition, the former background investigator was debarred by OPM.

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### **Former OPM Contract Background Investigator Sentenced for Falsifying Numerous Background Investigations**

In January 2012, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM Contract (USIS) Background Investigator.

Between September 2010 and August 2011, in numerous Reports of Investigations, a background investigator represented that he had interviewed a source, regarding the subject of the background investigation, or reviewed a record concerning 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, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator, costing taxpayers \$86,182.

The background investigator admitted to our criminal investigator, a FIS official, and a Department of Justice prosecutor that he randomly falsified reports. These false reports included the subject of a background investigation, as well as multiple source contacts and personal testimony that he falsely reported that he had interviewed. Furthermore, he also admitted that on numerous occasions he completely falsified documentary evidence, such as employment and residential record reports, to verify and corroborate information provided by the subject of the background investigation.

This background investigator pled guilty to making a false statement and was sentenced in September 2014, in the U.S. District Court for the District of Columbia, to serve three months in prison, serve 24 months of supervised probation, perform 100 hours of community service. The investigator was also ordered to pay a \$100 court assessment fee and restitution of \$86,182 to OPM.



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## **Former OPM Background Investigator Convicted of Falsifying Numerous Background Investigations**

In May 2014, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by an OPM Background Investigator.

From the summer of 2013 through April 2014, in ten Reports of Investigations, a background investigator represented that she had interviewed a source or reviewed a record regarding the subject of the background investigation, when in truth; she 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, or for receiving or retaining security clearances. Her false representations required FIS to reopen and reinvestigate numerous background investigations assigned to her, costing taxpayers approximately \$10,000.

OIG criminal investigators interviewed the background investigator who admitted she randomly falsified reports, to include multiple source contacts and personal testimony that she had interviewed. Furthermore, she also admitted that on numerous occasions she falsified documentary evidence, such as employment and residential record reports, to verify and corroborate information provided by the subject of the background investigation.

The background investigator pled guilty in September 2014, in the U.S. District Court for the District of Columbia, to making a false statement. This charge carries a statutory penalty of up to five years in prison and a fine of up to \$250,000. As part of her plea, the background investigator has agreed to pay an estimate of \$10,000 in restitution to OPM and is scheduled for sentencing in December 2014.

## **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](http://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.

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 727 hotline inquiries during the reporting period, with 230 pertaining to health care and insurance issues, and 497 concerning retirement or special investigation. The table on page 33 reports the summary of hotline activities including telephone calls, emails, and letters.

## OIG AND EXTERNAL INITIATED COMPLAINTS

Based on our knowledge of OPM program vulnerabilities, information shared by OPM program offices and contractors, and our liaison with other law enforcement agencies, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we initiated 64 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 787 health care fraud preliminary inquiry complaints. These efforts may potentially evolve into formal investigations.

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

## DEBARMENT INITIATIVE UPDATE

As discussed in previous reporting periods, the agency implemented a new Suspension and Debarment program, which became effective March 2013. During this reporting period, the OIG referred 14 cases to the agency for debarment action, for a total of 41 referrals since the inception of the program. OPM issued Debarment letters to 12 individuals between April 2014 and September 2014. The majority of cases we refer for debarment action are former Federal Investigative Service employees and contractors. These individuals have been removed from Government employment or from the relevant OPM contract; however, we feel 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.





# 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 33,161 active suspensions and debarments from the FEHBP.*

During the reporting period, our office issued 520 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 2,824 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.*

The following is a summary of our debarment actions.

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## Tennessee Physician Debarred After Medical Board Order to Suspend License to Practice

In September 2014, we debarred a Tennessee physician based on the Tennessee Board of Medical Examiners' (Board) decision to suspend the physician's medical license. In July 2013, the Board issued a Summary Order to immediately suspend the doctor's license as a result of its preliminary findings of misconduct, which they believed called for emergency action in order to protect the public health, safety and welfare prior to the initiation of formal disciplinary charges.

Specifically, the Board's actions were based on the Tennessee Department of Health, Division of Health Related Boards' (State) investigation in conjunction with the Narcotics Task Force in Greeneville, Tennessee into allegations of involving the physician's illegal drug use. The Task Force's investigation was initiated because they were contacted by one of the physician's former employee's who alleged that she was fired for refusing to smoke crack cocaine with him at work between his treatment of patients.

The State and Narcotics Task Force's investigation revealed that the physician:

- smoked crack cocaine on at least one occasion prior to seeing his patients;
- terminated an employee for refusing to smoke crack with him during work hours;
- admitted to planting drugs in the same employee's apartment; and was arrested for this incident and other illegal drug related activities; and,
- released on bond, entered into, but did not complete a residential treatment program. He was arrested again for violating the terms of his bond.

The physician waived his rights to challenge the allegations brought forth by the Board and agreed that cause existed to suspend his license. In September 2013, the physician signed the Board's Agreed Order to suspend his medical license for violating certain laws and regulations governing the practice of medicine and surgery in Tennessee without further adjudication.

Federal regulations state that the Office of Personnel Management may debar providers of health care services from participating in the FEHBP whose license to provide a health care service has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance or financial integrity.

Our debarment of the physician is for an indefinite period pending full reinstatement of the physician's medical license. This case was referred to us by our OIG Office of Investigations.

## Missouri Physician and Health Care Facility Debarred

We implemented the "debarment agreement" incorporated as a term and condition of the Settlement Agreement with a Missouri physician and his cancer treatment facility, executed in April 2014 with the DOJ. Accordingly, OPM has debarred the physician and his treatment facility from participating in the FEHBP effective April 2014.

The United States contended that the physician and treatment facility submitted, or caused to be submitted, claims for payment to the Medicare and Medicaid Programs; and to the FEHBP for drugs and services that were not rendered to Federal health care beneficiaries from January 2007 through December 2011.

Specifically, the United States asserted that the physician instructed employees responsible for preparing claims to:

- use a listing of the most commonly used procedures at the treatment facility instead of the patient's actual medical file; and,
- bill for a predetermined amount of certain cancer drugs at higher levels of the drugs than were actually provided to the beneficiary.

As a result of these instructions, the United States reimbursed the physician and his facility for drugs and services that were not actually provided to the Federal health care beneficiaries.

Although the physician and facility did not admit to the contentions made by the United States, they agreed to a final settlement to avoid the delay, inconvenience and expense of protracted litigation. The physician and the treatment facility agreed to:

- pay the United States \$2.9 million plus interest;
- accept a ten-year debarment from participating in the FEHBP; and
- receive an additional ten-year exclusion imposed by HHS from participating in Medicare, Medicaid and other Federal health care programs.

The physician and the treatment facility will not be eligible for reinstatement to the FEHBP until April 2024.







# STATISTICAL SUMMARY of ENFORCEMENT ACTIVITIES

## Judicial Actions:

Indictments and Informations. . . . .	41
Arrests. . . . .	29
Convictions. . . . .	30

## Judicial Recoveries:

Restitutions and Settlements . . . . .	\$41,199,535
Fines, Penalties, Assessments, and Forfeitures . . . . .	\$85,414 <sup>1</sup>

## Retirement and Special Investigations Hotline and Preliminary Inquiry Activity:

### HOTLINE

#### Referred to:

OPM Program Offices. . . . .	160
Other Federal Agencies . . . . .	180
Informational Only . . . . .	120
Inquiries Initiated . . . . .	4
Retained for Further Inquiry . . . . .	33
Total Received: . . . . .	497

### PRELIMINARY INQUIRY COMPLAINTS

Total Received: . . . . .	64
Total Closed: . . . . .	52

(Continued on next page)

<sup>1</sup>This 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.



## **Health Care Fraud Hotline and Preliminary Inquiry Complaint Activity:**

### **HOTLINE**

Referred to:

OPM Program Offices. . . . .	66
FEHBP Insurance Carriers or Providers. . . . .	52
Other Federal Agencies . . . . .	13
Informational Only . . . . .	85
Inquiries Initiated . . . . .	1
Retained for Further Inquiry . . . . .	13
Total Received: . . . . .	230

### **PRELIMINARY INQUIRY COMPLAINTS**

Total Received: . . . . .	787
Total Closed: . . . . .	572

## **Hotline Contacts and Preliminary Inquiry Complaints:**

Total Hotline Contacts and Preliminary Inquiries Received: . . . . .	1,578
Total Hotline Contacts and Preliminary Inquiries Closed: . . . . .	1,305

## **Administrative Sanctions Activity:**

FIS Cases Referred for Debarment and Suspension. . . . .	14
Health Care Debarments and Suspensions Issued . . . . .	520
Health Care Provider Debarment and Suspension Inquiries . . . . .	2,824
Health Care Debarments and Suspensions in Effect at End of Reporting Period. . . . .	33,161

APRIL 1, 2014 – SEPTEMBER 30, 2014

**STATISTICAL SUMMARY of ENFORCEMENT ACTIVITIES**



# APPENDICES

## APPENDIX I-A Final Reports Issued with Questioned Costs for Insurance Programs

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$16,593,732
B. Reports issued during the reporting period with findings	10	17,531,981
Subtotals (A+B)	15	34,125,713
C. Reports for which a management decision was made during the reporting period:	14	34,130,326
1. Disallowed costs	N/A	33,133,671
2. Costs not disallowed	N/A	996,655 <sup>2</sup>
D. Reports for which no management decision has been made by the end of the reporting period	1	(4,613) <sup>2</sup>
E. Reports for which no management decision has been made within 6 months of issuance	0	0

<sup>2</sup>Represents the net costs, which includes overpayments and underpayments, to insurance carriers.  
Underpayments are held (no management decision officially made) until overpayments are recovered.





## APPENDIX I-B

### Final Reports Issued with Questioned Costs for All Other Audit Entities

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	\$ 39,117
B. Reports issued during the reporting period with findings	1	2,011,529
Subtotals (A+B)	5	2,050,646
C. Reports for which a management decision was made during the reporting period:	3	6,162
1. Disallowed costs	N/A	6,162
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	2	2,044,484
E. Reports for which no management decision has been made within 6 months of issuance	1	32,955

## APPENDIX II

### Final Reports Issued with Recommendations for Better Use of Funds

APRIL 1, 2014 TO SEPTEMBER 30, 2014

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

# APPENDIX III

## Insurance Audit Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Report Number	Subject	Date Issued	Questioned Costs
1C-SF-00-14-014	Select Health in Murray, Utah	April 10, 2014	\$ 0
1A-99-00-13-046	Global Non-Covered Ambulance Claims for BlueCross and BlueShield Plans in Washington, D.C.	April 17, 2014	1,423,823
1C-GG-00-13-063	Geisinger HealthPlan in Danville, Pennsylvania	May 1, 2014	652,129
1D-FX-00-14-001	Health Alliance HMO in Urbana, Illinois	May 5, 2014	0
1C-64-00-13-060	HealthSpan Integrated Care (formerly Kaiser Foundation Health Plan of Ohio) in Cleveland, Ohio	May 7, 2014	58,358
1C-MK-00-13-052	Blue Choice in Rochester, New York	May 7, 2014	2,143,534
1C-SW-00-14-004	HealthAmerica Pennsylvania, Inc. in Harrisburg, Pennsylvania	May 7, 2014	0
1C-UB-00-14-020	Aetna Open Access of Memphis in Blue Bell, Pennsylvania	May 14, 2014	0
1A-10-15-13-058	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	June 6, 2014	3,618,301
1C-CK-00-13-064	FirstCare Health Plans of West Texas in Austin, Texas	June 24, 2014	366,402
1C-2C-00-13-056	Piedmont Community HealthCare in Lynchburg, Virginia	July 9, 2014	171,996
1C-26-00-14-024	HealthAmerica Pennsylvania in Pittsburgh, Pennsylvania	July 28, 2014	0
1C-X5-00-14-005	HealthPlus of Michigan, Inc. in Flint, Michigan	July 28, 2014	0
1C-JG-00-14-010	Fallon Community HealthPlan in Worcester, Massachusetts	July 30, 2014	0
1A-99-00-13-061	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.	August 19, 2014	7,878,473
1C-22-00-14-023	Aetna Health Fund in Blue Bell, Pennsylvania	August 22, 2014	0
1A-10-13-14-003	Highmark Inc. in Camp Hill, Pennsylvania	August 22, 2014	8,672
<b>TOTALS</b>			<b>\$16,321,688</b>



## APPENDIX IV

### Life Insurance Audit Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Report Number	Subject	Date Issued	Questioned Costs
2A-II-00-13-065	Federal Employees' Group Life Insurance Program as Administered by the Metropolitan Life Insurance Company for Contract Years 2009 through 2012 in Bridgewater, New Jersey	July 9, 2014	\$1,210,293
<b>TOTALS</b>			<b>\$1,210,293</b>

## APPENDIX V

### Internal Audit Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

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.	April 10, 2014
4A-IS-00-13-062	The Federal Investigative Services' Case Review Process over Background Investigations in Washington, D.C.	June 4, 2014

## APPENDIX VI

### Combined Federal Campaign Audit Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Report Number	Subject	Date Issued
3A-CF-00-13-051	The 2005 through 2012 Combined Federal Campaigns as Administered by the Metropolitan Arts Partnership in Sacramento, California	July 10, 2014



## APPENDIX VII

### Information Systems Audit Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Report Number	Subject	Date Issued
4A-IS-00-14-017	Information Technology Security Controls of OPM's Investigations, Tracking, Assigning, and Expediting System in Washington, D.C.	April 3, 2014
4A-RI-00-14-018	Information Technology Security Controls of OPM's Services Online System in Washington, D.C.	April 3, 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	May 6, 2014
4A-CI-00-14-015	Information Technology Security Controls of OPM's Development Test Production General Support System in Washington, D.C.	June 6, 2014
1A-10-67-14-006	Information Systems General and Application Controls at Blue Shield of California in San Francisco, California	July 9, 2014
4A-RI-00-14-036	Information Technology Security Controls of OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems in Washington, D.C.	August 19, 2014

## APPENDIX VIII

### Evaluation Reports Issued

APRIL 1, 2014 TO SEPTEMBER 30, 2014

Report Number	Subject	Date Issued
4A-CI-00-14-028	Status of Cloud Computing Environments within OPM in Washington, D.C.	July 9, 2014



# APPENDIX IX

## Summary of Audit Reports More Than Six Months Old Pending Corrective Action

APRIL 1, 2014 TO SEPTEMBER 30, 2014

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 Fiscal Year 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; 3 open recommendations	November 10, 2010
4A-CF-00-10-043	Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 1 open recommendation	March 4, 2011
4A-CI-00-11-016	Information Technology Security Controls for OPM's Enterprise Server Infrastructure General Support System in Washington, D.C.; 3 total recommendations; 1 open recommendation	May 16, 2011
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; 6 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

# APPENDIX IX

## Summary of Audit Reports More Than Six Months Old Pending Corrective Action

APRIL 1, 2014 TO SEPTEMBER 30, 2014

(Continued)

Report Number	Subject	Date Issued
1A-99-00-11-022	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	January 11, 2012
4A-RI-00-12-034	Insecure Password Reset Process on Agency-owned Information Systems in Washington, D.C.; 3 total recommendations; 1 open recommendation	February 7, 2012
4A-CF-00-09-014	OPM's Interagency Agreement Process in Washington, D.C.; 8 total recommendations; 2 open recommendations	March 28, 2012
1A-99-00-12-001	Global Omnibus Budget Reconciliation Act of 1993 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 1 open recommendation	July 16, 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; 15 open recommendations	July 16, 2012
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; 8 open recommendations	November 5, 2012
4A-CF-00-12-039	OPM's Fiscal Year 2012 Consolidated Financial Statement in Washington, D.C.; 3 total recommendations; 1 open recommendation	November 15, 2012
1D-80-00-12-045	Information Systems General and Application Controls at EmblemHealth in New York, New York; 12 total recommendations; 2 open recommendations	December 10, 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-10-67-12-004	BlueShield of California in San Francisco, California; 13 total recommendations; 2 open recommendations	January 10, 2013
1A-99-00-12-055	Global Assistant Surgeon Claim Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendations	February 21, 2013
1A-99-00-12-029	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 7 total recommendations; 4 open recommendations	March 20, 2013



# APPENDIX IX

## Summary of Audit Reports More Than Six Months Old Pending Corrective Action

APRIL 1, 2014 TO SEPTEMBER 30, 2014

(Continued)

Report Number	Subject	Date Issued
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; 4 open recommendations	July 19, 2013
1A-99-00-13-004	Global Continuous Stay Claims for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 5 open recommendations	August 20, 2013
1A-10-00-13-012	Information Systems General and Application Controls at WellPoint, Inc. in Roanoke, Virginia; 10 total recommendations; 4 open recommendations	September 10, 2013
1A-10-41-12-050	Florida Blue in Jacksonville, Florida; 13 total recommendations; 6 open recommendations	September 10, 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; 11 open recommendations	November 8, 2013
4A-CI-00-13-021	Federal Information Security Management Act for FY 2012 in Washington, D.C.; 16 total recommendations; 10 open recommendations	November 21, 2013
1A-99-00-13-003	Global Claims where Amounts Paid Exceeded Covered Charges for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 4 open recommendations	November 22, 2013
1A-99-00-13-032	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 7 total recommendations; 5 open recommendations	November 22, 2013
4A-CF-00-13-034	OPM's Fiscal Year 2013 Consolidated Financial Statement in Washington, D.C.; 1 total recommendation; 1 open recommendation	December 13, 2013
1B-32-00-13-017	National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia; 12 total recommendations; 8 open recommendations	December 23, 2013
1A-10-17-13-026	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois; 12 total recommendations; 8 open recommendations	January 28, 2014
1A-10-17-13-019	Health Care Service Corporation in Chicago, Illinois; 8 total recommendations; 1 open recommendation	March 28, 2014

APRIL 1, 2014 – SEPTEMBER 30, 2014

**APPENDICES**



# APPENDIX X

## Most Recent Peer Review Results

APRIL 1, 2014 TO SEPTEMBER 30, 2014

*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 26, 2012	Pass <sup>3</sup>
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 <sup>3</sup>
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 <sup>4</sup>
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 <sup>4</sup>

<sup>3</sup>A 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.

<sup>4</sup>A 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.



# APPENDIX XI

## Investigative Recoveries

APRIL 1, 2014 TO SEPTEMBER 30, 2014

OIG Case Number <sup>5</sup>	Case Category	Action <sup>5</sup>	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
C-12-00243	Federal Investigative Services	Administrative	\$ 108,521	\$ 108,521	\$ 0
I 2010 00458	Federal Investigative Services	Administrative	92,638	92,638	0
I 2010 00824	Federal Investigative Services	Administrative	184,987	184,987	0
I 2011 00755	Federal Investigative Services	Administrative	234,607	234,607	0
I-12-00246	Federal Investigative Services	Administrative	46,667	46,667	0
I 2010 00873	Federal Investigative Services	Criminal	173,446	173,446	100
I-12-00185	Federal Investigative Services	Criminal	86,182	86,182	100
<b>TOTAL</b>	<b>Federal Investigative Services Fraud</b>		<b>\$ 927,048</b>	<b>\$927,048</b>	<b>\$ 200</b>
I 2010 00607	Healthcare and Insurance	Civil	202,976	7,300,000	0
I 2011 00027	Healthcare and Insurance	Civil	11,456	520,000	0
I 2011 00036	Healthcare and Insurance	Civil	1,178,122	56,500,000	0
I 2011 00827	Healthcare and Insurance	Civil	289,380	3,739,325	0
I-12-00084	Healthcare and Insurance	Civil	439,402	35,000,000	0
I-12-00325	Healthcare and Insurance	Civil	124,215	2,945,187	0
I-13-00391	Healthcare and Insurance	Civil	144,292	1,152,000	0
I-13-00403	Healthcare and Insurance	Civil	68,988	2,570,512	0
I-13-00849	Healthcare and Insurance	Civil	7,574	475,000	0
I-13-00849	Healthcare and Insurance	Civil	24,518	1,500,000	0
I-13-00849	Healthcare and Insurance	Civil	1,933	100,000	0
I-13-00849	Healthcare and Insurance	Civil	24,632	1,500,000	0
I-13-01027	Healthcare and Insurance	Civil	2,497	47,197	0
I-14-00250	Healthcare and Insurance	Civil	4,494	80,779	0
I 2010 00108	Healthcare and Insurance	Criminal	103,184	1,503,442	200
I 2011 00023	Healthcare and Insurance	Criminal	0	0	58,814
I 2011 00023	Healthcare and Insurance	Criminal	0	0	100
I 2011 00023	Healthcare and Insurance	Criminal	15,840	39,230	300
I 2011 00051	Healthcare and Insurance	Criminal	\$ 325,000	\$ 325,000	\$ 0
I-12-00333	Healthcare and Insurance	Criminal	0	0	200
I-13-00173	Healthcare and Insurance	Criminal	0	0	100
I-13-00173	Healthcare and Insurance	Criminal	6,363	100,772	25,100
I-13-00853	Healthcare and Insurance	Criminal	0	4,137	100
I-13-00853	Healthcare and Insurance	Criminal	0	161,908	100
<b>TOTAL</b>	<b>Healthcare and Insurance Fraud</b>		<b>\$2,974,866</b>	<b>\$115,564,489</b>	<b>\$85,014</b>
I 2010 00028	Retirement Services	Criminal	7,937	7,937	0
I-12-00601	Retirement Services	Criminal	19,919	29,902	100
I-13-00589	Retirement Services	Criminal	50,945	50,945	0
I-14-00786	Retirement Services	Criminal	218,820	373,815	100
<b>TOTAL</b>	<b>Retirement Services Fraud</b>		<b>\$297,621</b>	<b>462,599</b>	<b>200</b>
<b>GRAND TOTAL</b>			<b>\$4,199,535</b>	<b>\$116,954,136</b>	<b>\$85,414</b>

<sup>5</sup>Cases that are listed multiple times indicate there were multiple subjects.

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**APPENDICES**

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