

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



SEMIANNUAL REPORT TO CONGRESS

April 1, 2011 – September 30, 2011

OFFICE OF THE INSPECTOR GENERAL



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$47,024,794
Management Commitments to Recover Funds	\$42,229,973
Recoveries Through Investigative Actions	\$5,704,728

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	32
Evaluation Reports Issued	1
Investigative Cases Closed	88
Indictments and Informations	26
Arrests	21
Convictions	31
Hotline Contacts and Complaint Activity	482
Health Care Provider Debarments and Suspensions	368
Health Care Provider Debarment and Suspension Inquiries	2,640

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
Office of the Inspector General



**SEMIANNUAL
REPORT
TO
CONGRESS**

April 1, 2011 - September 30, 2011

INSPECTOR GENERAL'S MESSAGE



In the course of observing our investigative work over an extended period, I have noted the continuous occurrence of cases involving the improper payment of monthly retirement and survivor benefits to the accounts of deceased annuitants. These payments were frequently used by a relative or guardian of the deceased annuitant who neglected to report the death and, in many cases, led the U.S. Office of Personnel Management (OPM) to believe the annuitant was still alive by forging their signature on an inquiry form from OPM. The high dollar amount and length of time in which these improper payments often occurred led me to conclude that a more aggressive approach needed to be taken by OPM to prevent this from continuing.

In 2005, my office began a study of best practices related to preventing improper payments to deceased annuitants. We met with several benefit-paying Federal agencies and a major corporation, and discussed procedures and internal controls used to prevent and detect such improper payments. This study resulted in a report provided to the Director of OPM in July 2005, with recommendations for improvements related to preventing improper payments from the Federal Government's *Civil Service Retirement and Disability Fund* (CSRDF). This report was then updated and reissued in January 2008, reflecting changes since the first report and providing additional recommendations. Since then, an OPM working group of subject matter experts and the Office of the Inspector General (OIG) staff has met regularly to discuss the recommendations and other issues related to preventing improper payments. While a number of improvements were put in place, it became clear they were only partial remedies. Therefore, in September 2011, my office issued a third report to again highlight the need for improvements in this area.

This report, "*Stopping Improper Payments to Deceased Annuitants*," provided the status of efforts to address our previous recommendations, including monitoring those recommendations which we deemed closed. More importantly, the report attempted to demonstrate the need to stop the flow of improper payments from the CSRDF to deceased annuitants, which have averaged \$120 million annually over the last five years. While we are concerned with all post-death improper payments, as each one requires time and effort to recover, our paramount concern is with the improper payments resulting when an annuitant's death is not reported or detected and payments continue, sometimes for many years. Our experience reveals that these improper payments often cannot be recovered.

Each year new cases are identified which support this concern. As an example, our report noted the case of an annuitant's son who continued to fraudulently receive benefits until 2008, 37 years after his father's death in 1971. The improper payments in this case exceeded \$515,000 and was only reported to OPM when the son died. The improper payments were not recovered. While this is certainly a larger than average total improper payment, it is not unusual for improper payments to exceed \$100,000. Despite the improvements that have been implemented, there remains a high probability that the egregious loss of monies from the CSRDF will continue.

April 1, 2011 – September 30, 2011



Based on our recommendations, OPM has taken positive steps to address this issue. Regular meetings over the last three years between subject matter experts in OPM's Retirement Services, Retirement Policy, the Office of the Chief Financial Officer, and the OIG have led to enhancements in procedures. These initiatives need to be further refined and institutionalized, then monitored on a continuous basis by senior program managers to assure they are effective, with any necessary modifications and improvements developed and implemented as needed.

Currently the key initiatives include:

- An annual computer match between the OPM retirement annuity roll and the Social Security Death Master File to identify deceased annuitants receiving payments;
- Systematically sampling and contacting the annuitant population over 90 years old to obtain a signed response confirming their vital status and validating their correspondence address;
- An analysis of returned correspondence, focusing on the Internal Revenue Service Form 1099R and by contacting the effected annuitants to determine why the mail was returned; and,
- Making an effort to improve and streamline the reclamation system through which the U.S. Department of the Treasury reclaims improper payments to deceased annuitants from the financial institution accounts where they were electronically deposited, and taking action to assure that an immediate demand is made on the financial institutions to recover improper payments not recovered through the reclamation process.

In addition, we have strongly recommended that OPM establish a permanent working group of retirement program subject matter experts to improve program integrity. This group would identify and explore risk areas and take advantage of the wealth of information on the OPM annuity roll to develop data mining programs to search for anomalies that could indicate possible improper payments or fraud.

The steps taken so far by OPM, while encouraging, do not provide an adequate solution to the problem. What is needed is a concerted effort to eliminate these significant improper payments. Our report reemphasizes our belief that sufficient funds and resources of OPM must be focused on this serious matter in order to bring about a full measure of success. OPM Director John Berry and I agree that it is time to stop, once and for all, this waste of taxpayer money.

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

Patrick E. McFarland
Inspector General

MISSION STATEMENT



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

WE ACCOMPLISH OUR MISSION BY:

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

Guiding Principles

WE ARE COMMITTED TO:

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

Strategic Objectives

THE OIG WILL:

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

April 1, 2011 – September 30, 2011

TABLE OF CONTENTS



PRODUCTIVITY INDICATORS.....	Inside Cover
INSPECTOR GENERAL'S MESSAGE	i
MISSION STATEMENT.....	iii
FIELD OFFICES	vii
AUDIT ACTIVITIES	1
Health Insurance Carrier Audits	1
Information Systems Audits	7
Internal Audits	12
Special Audits	13
ENFORCEMENT ACTIVITIES	17
Investigative Cases.....	17
Administrative Sanctions of FEHBP Health Care Providers	25
LEGAL ACTIVITIES	27
STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES.....	29
APPENDIX I: Final Reports Issued With Questioned Costs for Insurance Programs	31
APPENDIX II-A: Final Reports Issued With Recommendations for All Other Audit Entities	32
APPENDIX II-B: Final Reports Issued With Recommendations for Better Use of Funds	32
APPENDIX III: Insurance Audit Reports Issued	33
APPENDIX IV: Internal Audit Reports Issued	34
APPENDIX V: Combined Federal Campaign Audit Reports Issued	34
APPENDIX VI: Information Systems Audit Reports Issued	35
APPENDIX VII: Evaluation Reports Issued	35
APPENDIX VIII: Summary of Audit Reports More Than Six Months Old Pending Corrective Action	36
APPENDIX IX: Most Recent Peer Review Results	39
APPENDIX X: Investigative Recoveries	40
INDEX OF REPORTING REQUIREMENTS	42

April 1, 2011 – September 30, 2011



FIELD OFFICES



April 1, 2011 – September 30, 2011





AUDIT ACTIVITIES

Health Insurance Carrier Audits

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

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

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

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

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

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

During the current reporting period, we issued 23 final audit reports on organizations participating in the FEHBP, of which 12 contain recommendations for monetary adjustments in the amount of \$47 million due the OPM administered trust funds.

April 1, 2011 – September 30, 2011



COMMUNITY-RATED PLANS

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

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

Community-rated audits focus on ensuring that:

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

Loading is a rate adjustment that the FEHBP makes to the basic benefit package offered by a community-rated plan. For example, the FEHBP provides coverage for dependent children until age 26. Therefore, the FEHBP rates may be increased because of the additional costs the plan incurs by extending coverage to age 26.

During this reporting period, we issued 15 final audit reports on community-rated plans. These reports contain recommendations that require the health plans return over \$4 million to the FEHBP.

Aetna Open Access of Georgia

BLUE BELL, PENNSYLVANIA

Report No. 1C-2U-00-11-003

APRIL 13, 2011

Aetna Open Access of Georgia provides comprehensive medical services to its members in the Athens and Atlanta areas of Georgia. This audit of the plan covered contract years 2006 through 2010. During the period, the FEHBP paid the plan approximately \$281.8 million in premiums.

We identified \$1,273,625 in inappropriate health

benefit charges to the FEHBP in 2007. In addition, we determined the FEHBP is due \$213,730 for investment income lost as a result of the overcharges.

Inappropriate Charges Amount to Approximately \$1.5 Million

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

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

Keystone Health Plan East, Inc. PHILADELPHIA, PENNSYLVANIA

Report No. 1C-ED-00-10-053

JULY 25, 2011

Keystone Health Plan East, Inc. provides comprehensive medical services to its members throughout the Philadelphia area of Pennsylvania. This audit of the plan covered contract years 2008 and 2009. During the period, the FEHBP paid the plan approximately \$339 million in premiums.

The audit identified \$2,024,199 in inappropriate health benefit charges to the FEHBP in 2009. In addition, we



determined the FEHBP is due \$144,224 for investment income lost as a result of the overcharges. The overcharges occurred because the plan did not apply the largest SSSG discount to the FEHBP rates and overcharged the FEHBP's vision and dental benefits.

**Overcharges
Amount to Over
\$2 Million**

of all FEHBP subscribers are enrolled in the BCBS plans.

We issued two BCBS experience-rated final audit reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors identified \$39.0 million in questionable costs charged to the FEHBP contract. The BCBS Association agreed with \$29.3 million of the identified overpayments.

EXPERIENCE-RATED PLANS

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

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

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

During this reporting period, we issued seven experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$42.9 million in inappropriate charges and lost investment income to the FEHBP. A summary of five of the seven issued final reports is provided to highlight our notable audit findings.

BlueCross BlueShield Service Benefit Plan

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

BlueCrossBlueShield of Florida

JACKSONVILLE, FLORIDA

Report No. 1A-10-41-10-012

MAY 12, 2011

Our audit of the FEHBP operations at BCBS of Florida covered claim payments from January 2006 through September 2009, miscellaneous health benefit payments and credits and cash management activities from January 2006 through July 2009, as well as administrative expenses from 2006 through 2008. Due to concerns with this plan's processing of health benefit refunds, we also expanded our review of refunds through December 2009. From 2006 through 2008, the plan paid approximately \$3.2 billion in FEHBP health benefit charges and \$181 million in administrative expenses.

Our auditors questioned \$21,420,650, consisting of \$19,101,493 in health benefit overcharges, \$2,718,548 in cash management activities, and \$399,391 in net administrative expense undercharges. Our findings included the following:

- \$17,928,307 for unreturned health benefit refunds and recoveries from providers and subscribers, and \$490,343 for lost investment income on refunds and recoveries that were either not returned to the FEHBP or not returned in a timely manner;
- \$2,718,548 in excess FEHBP funds that were held by BCBS of Florida;
- \$556,432 in duplicate claim payments;
- \$126,411 in net overpayments due to claim pricing errors;

April 1, 2011 – September 30, 2011



Auditors Question Over \$21.4 Million in Overcharges

- \$41,186 for administrative expense charges that were unallowable and/or did not benefit the FEHBP;
- \$5,572 for other administrative expense overcharges; and,
- \$446,149 for plan employee pension cost undercharges.

Of these questioned charges, the BCBS Association agreed with \$18,702,102 and disagreed with \$2,718,548. The contested amount represents the questioned excess FEHBP funds that were held by BCBS of Florida. However, even though the BCBS Association contested this amount, the plan returned these funds to the FEHBP. Additionally, lost investment income on the questioned charges totaled \$4,633.

WellPoint, Inc.

MASON, OHIO

Report No. 1A-10-39-10-011

MAY 13, 2011

WellPoint, Inc. includes 14 BlueCross and/or BlueShield plans in various states. Our audit of the FEHBP operations at WellPoint, Inc. covered administrative expenses from 2006 through 2008, as well as miscellaneous health benefit payments and credits and cash management activities from January 2006 through June 2009. During the period 2006 through 2008, WellPoint, Inc. paid approximately \$10.8 billion in FEHBP health benefit charges and \$489 million in administrative expenses.

Our auditors questioned \$4,680,154 as follows:

- \$2,526,893 for unreturned health benefit refunds and recoveries and \$119,675 for lost investment income on refunds and recoveries that were either not returned to the FEHBP or not returned in a timely manner;

- \$1,059,884 for administrative expense charges that were unallowable and/or did not benefit the FEHBP and \$64,899 for lost investment income on these charges;
- \$699,717 in net administrative expense overcharges because WellPoint, Inc. did not properly charge costs that were incurred under sale and leaseback arrangements;
- \$177,756 for plan employee post-retirement benefit cost overcharges;
- \$67,751 for other administrative expense overcharges; and,
- \$36,421 for executive compensation cost undercharges.

**WellPoint, Inc.
Agrees with
\$3.9 Million
in Questioned
Charges**

The BCBS Association and/or WellPoint, Inc. agreed with \$3,917,672 of these questioned charges. Additionally, lost investment income on the questioned charges totaled \$160,547.

Global Coordination of Benefits for

**BLUECROSS AND BLUESHIELD PLANS
WASHINGTON, D.C.**

Report No. 1A-99-00-10-055

JUNE 8, 2011

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

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



Using our data warehouse, we performed a computer search on the BCBS claims database to identify claims for services that were paid from January 2009 through May 2010 and potentially not coordinated with Medicare. We determined that 56 of the 63 plan sites did not properly coordinate claim charges with Medicare. As a result, the FEHBP incorrectly paid these claims when Medicare was the primary insurer.

For 71 percent of the 15,409 claim lines questioned, no information existed in the BCBS Association's national claims system to identify Medicare as the primary payer when the claims were paid. However, even after the Medicare information was added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP.

We determined that the FEHBP was overcharged \$7,742,389 for these COB errors. The BCBS Association and/or plans agreed with \$3,529,991 and disagreed with \$4,212,398 of the questioned claim overcharges. Most of the contested amount represents COB errors where recovery efforts were initiated by the

plans before the audit started. However, since the plans had not recovered and returned these overpayments to the FEHBP by the response due date

**FEHBP Overcharged
\$7.7 Million for
Coordination of
Benefits Errors**

to our draft report, we continued to question these overpayments in the final report.

EMPLOYEE ORGANIZATION PLANS

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

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

We issued one employee organization plan audit report during this reporting period for the American Postal Workers Union Health Plan.

American Postal Workers Union Health Plan

GLEN BURNIE, MARYLAND

Report No. 1B-47-00-11-002

SEPTEMBER 1, 2011

The American Postal Workers Union Health Plan (Plan) is an experience-rated employee organization plan. Enrollment is open to all postal service employees who are members of the American Postal Workers Union (Union) and all other Federal employees and annuitants that elect to become associate members of the Union. The Union is the sponsor of the Plan. Members have a choice of enrollment in a High Option or a Consumer Driven Health Plan.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, administrative expenses, and cash management activities from 2005 through 2009. During this period, the Plan paid approximately \$2.6 billion in FEHBP health benefit charges and \$249 million in administrative expenses.

Our auditors questioned \$17,314 in administrative expense charges and also identified procedural findings regarding the Plan's Fraud and Abuse program. The Plan agreed with the questioned charges. Additionally, lost investment income on the questioned charges totaled \$2,642.

April 1, 2011 – September 30, 2011



EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

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

Members of experience-rated plans have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one health care provider over another has monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued two experience-rated comprehensive medical plan audit reports during this reporting period.

Group Health Incorporated NEW YORK, NEW YORK

Report No. 1D-80-00-10-046

JULY 27, 2011

Group Health Incorporated (Plan) is an experience-rated health plan offering comprehensive medical benefits to Federal enrollees and their families. Enrollment is open to all Federal employees and annuitants who live or work in the Plan's service area, which includes New York and the surrounding counties in northern New Jersey.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, administrative expenses, statutory reserve payments, and cash management activities from 2004 through 2009. During this period, the Plan paid approximately \$1.1 billion in FEHBP health benefit charges, \$82 million in administrative expenses, and \$12 million in statutory reserve payments.

Our auditors questioned \$3,626,299 as follows:

- \$2,788,625 for unreturned prescription drug rebates and \$75,822 for lost investment income on rebates that were either not returned to the FEHBP or not returned in a timely manner;
- \$566,301 for plan employee pension cost overcharges in 2006, 2008 and 2009, as well as \$550,057 for undercharges in 2004, 2005 and 2007;
- \$457,073 for unsupported settlement charges and \$141,549 for lost investment income on these unsupported charges; and,
- \$122,892 for uncashed health benefit checks and \$24,094 for lost investment income on these uncashed checks that were not returned to the FEHBP.

The Plan agreed with all of these questioned charges. Additionally, lost investment income on the questioned charges totaled \$63,893.

**Group Health
Incorporated
Agrees with
\$3.6 Million in
Questioned
Charges**



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 for Federal employment. 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. With recent high-profile security incidents involving personally identifiable information, privacy has emerged as a major management challenge for most Federal agencies and OPM is no exception.

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

During the current reporting period, we issued six final audit reports on information systems for OPM programs and health insurance carriers.

Information Technology Security Controls of OPM's Enterprise Server Infrastructure WASHINGTON, D.C.

Report No. 4A-CI-00-11-016

MAY 16, 2011

FISMA is designed to ensure that the information systems and data supporting operations are adequately protected. FISMA emphasizes that agencies implement security planning as part of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's Inspector General.

We audited four OPM systems and the agency's overall information security program to determine compliance with FISMA requirements defined in the Office of Management and Budget's (OMB) FY 2011 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management.

The Enterprise Server Infrastructure (ESI) is one of OPM's three primary general support systems and is owned by the Chief Information Officer (CIO). ESI is

April 1, 2011 – September 30, 2011



a mainframe system that supports OPM's processing of retirement and health benefits related actions for current and former Federal employees.

The most significant issue identified during this audit is the lack of documented common controls. The National Institute of Standards and Technology (NIST) 800-53 Revision 3 details the security controls that should be in place for Federal information systems. Some of these controls are inherited from the agency's general support systems. These inherited controls need not be tested by system owners whose applications reside on general support systems such as ESI.

However, the CIO has not documented common controls provided by ESI or informed the owners who rely on this support system of this fact. As a result, other OPM system owners are not efficiently performing the required continuous monitoring of their system's IT security controls. Some common controls are being needlessly retested when system owners could be relying on the testing already performed by the ESI owner; conversely, controls that are assumed to be common controls, may, in fact, not be. In these cases, system-level controls may not be tested at all.

Information Technology Security Controls for OPM's Presidential Management Fellows System

WASHINGTON, D.C.

Report No. 4A-HR-00-11-017

MAY 16, 2011

The Presidential Management Fellows system (PMF) is one of OPM's 43 critical IT systems and provides web-based information about the PMF program to potential PMF candidates, Federal agencies, and OPM staff. The PMF system is also used by Federal agencies and Fellows candidates to facilitate the fellowship selection process.

Our audit identified several weaknesses associated with privacy-related documentation, auditing user accounts, and password creation. The system owners implemented corrective actions before the final audit report was issued, and are now in full compliance with FISMA requirements.

Information Technology Security Controls for OPM's Consolidated Business Information System

WASHINGTON, D.C.

Report No. 4A-CF-00-11-015

JUNE 1, 2011

The Chief Financial Officer (CFO) owns the Consolidated Business Information System (CBIS). This financial management system provides general ledger, accounts payable, accounts receivable, purchasing, procurement, budgeting, reporting, and other financial resources management functions.

Our review of the CBIS security program showed that it is in compliance with most FISMA requirements, including certification and accreditation, security categorization, risk assessment, testing of controls, and contingency planning. However, we noted weaknesses in the system's privacy program, the plan of action and milestones (POA&M), and a lack of controls required by NIST 800-53 Revision 3.

In addition, we reported a significant deficiency related to the segregation of duties within the CBIS application. The CFO developed a segregation of duties policy, but the application did not have the technical settings in place to enforce these rules. CFO officials indicated that they did not have a firm understanding of which CBIS user roles should be segregated within the application, and that the existing CBIS segregation of duties policy was inaccurate.

Information Technology Security Controls for OPM's Center for Talent Services General Support System

WASHINGTON, D.C.

Report No. 4A-CI-00-11-043

SEPTEMBER 28, 2011

The Center for Talent Services General Support System (CTS GSS) is one of OPM's three general support systems. OPM's Human Resources Solutions (HRS) is responsible for this system. It provides design,



development, and operation of human resources systems for a variety of functions and customers across the Government. It is also responsible for the software development, maintenance, and operations for those systems.

HRS is in compliance with FISMA requirements including certification and accreditation, security categorization, testing of controls, privacy, and the POA&M process.

However, we found weaknesses related to contingency planning and physical access controls. Specifically, the CTS GSS contingency plan has only been tested with tabletop exercises instead of the functional exercise that is required by NIST SP 800-84. As a result, there could be unforeseen problems during a real disaster recovery situation that might affect the CTS GSS's ability to support the systems relying on this platform. Also, we found that the facility hosting the system hardware does not have an automated fire suppression system. Instead, system owners are relying on manual procedures to control a potential fire which are probably not as effective and could lead to a significant disaster event.

Information Systems General and Application Controls at CVS Caremark

SCOTTSDALE, ARIZONA AND
NORTHBROOK, ILLINOIS

Report No. 1H-01-00-10-057

MAY 17, 2011

Caremark is the pharmacy benefit manager responsible for processing prescription drug claims on behalf of the following FEHBP insurance carriers:

- Blue Cross Blue Shield Federal Employee Program;
- Mail Handlers Benefit Plan;
- Rural Carrier Benefit Plan; and,
- National Association of Letter Carriers.

Our audit focused on Caremark's claims processing applications and the various processes and information technology (IT) systems used to support these

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

Security Management

Caremark has established a comprehensive series of IT policies and procedures to create an awareness of IT security. We verified that Caremark's policies and procedures are maintained on the company's intranet site in a manner that is easily accessible by employees.

Access Controls

We found that Caremark has implemented numerous physical controls to prevent unauthorized access to its facilities, as well as logical controls to prevent unauthorized access to its information systems. However, we did note several opportunities for improvement related to Caremark's physical and logical access controls.

Configuration Management

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

Contingency Planning

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

Claims Adjudication

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

Health Insurance Portability and Accountability Act (HIPAA)

Caremark appears to be in compliance with the HIPAA security, privacy, and national provider identifier regulations.

April 1, 2011 – September 30, 2011



Follow-up Review of Information Systems General and Application Controls at CareFirst BlueCross BlueShield and the Federal Employee Program Operations Center

WASHINGTON, D.C.

Report No. 1A-10-85-11-029

JUNE 23, 2011

We initiated this follow-up review because of concerns regarding several instances of premature closure of recommendations stemming from IT audits of FEHBP insurance carrier systems.

The original audit of CareFirst and the Federal Employee Program (FEP) Operations Center was scheduled in 2008 because of the high risk associated with this health plan. CareFirst is the largest plan in the BCBS service benefit plan. In addition, CareFirst hosts the FEP Operations Center, which is the entity that manages the national claims processing system (FEP Express) for the BCBS FEP. All claims for BCBS Federal members are processed by FEP Express impacting \$25.6 billion in claims in 2010.

As a result of our audit we made 13 recommendations for improvement in a wide range of business process and technical areas, including the overall IT security environment, business continuity, access controls, and application processing controls for the FEP Express system. Several of the recommendations were made to correct systemic problems that impacted not just the CareFirst plan, but all BCBS plans using FEP Express to process federal employee claims.

In May 2010, we discovered that all recommendations were closed by OPM's Healthcare and Insurance office without proper documentation that corrective action had been completed. The OIG shares responsibility for audit resolution by reviewing corrective actions and rendering an opinion regarding their relevance and effectiveness at mitigating the weaknesses identified during our audits. In this case, we were not involved in this process. Closing audit recommendations without following the established process allows health plans to avoid correcting significant weaknesses as well as wastes limited audit resources expended to identify the weaknesses.

The objective of this follow-up review was to evaluate the current status of each recommendation and determine which, if any, of the recommendations should be reopened.

We concluded that 9 of the 13 recommendations were adequately addressed, but that 4 recommendations had not been fully implemented. We also issued two new recommendations that address the following outstanding weaknesses:

- **CareFirst Business Impact Assessment (BIA):** As part of the overall risk management process, CareFirst conducted a BIA to evaluate the degree to which disruptions to various business processes would have on the organization as a whole. However, we found that the CareFirst BIA had not been updated since March 2005 and is still outdated.
- **Comprehensive Medical Edits:** The original test of FEP Operations Center's FEP Express claims processing application revealed that this system did not have adequate medical editing capabilities to detect clinical inconsistencies in insurance claims. It is common practice for health claims processing systems to include such controls to prevent payments for abusive or fraudulent billing. FEP Express had not been modified to address these weaknesses.



Follow-up Review of Information Systems General and Application Controls at American Postal Workers Union Health Plan

GLEN BURNIE, MARYLAND

Report No. 1B-47-00-11-044

JUNE 27, 2011

Our initial 2001 audit of the American Postal Workers Union Health Plan (APWU) revealed significant weaknesses in APWU's IT infrastructure. Subsequently, in 2007, we conducted an audit of APWU as a review of the information systems general and application controls as well as a reevaluation of the 2001 recommendations.

The 2007 audit revealed that APWU had a variety of inadequate policies, procedures, and a very limited IT security program. We made 46 recommendations for improvement in a wide range of business process and technical areas, including the overall IT security environment, business continuity, access controls, and application processing controls for APWU's claims adjudication system. In January 2009, we discovered that all recommendations were closed by OPM's Healthcare and Insurance office without proper documentation that corrective actions had been completed.

Our follow-up review in 2011 showed that APWU has made substantial progress in implementing a comprehensive IT security program, and that it has fully addressed 41 of the 46 audit recommendations. We also issued one new recommendation resulting from the follow-up review. The five unimplemented recommendations and the new recommendation are related to weak or missing physical and logical access controls, medical edits, and an inadequate fraud investigations program.

April 1, 2011 – September 30, 2011



Internal Audits

OPM INTERNAL PERFORMANCE AUDITS

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

Human Resources Solutions Vendor Management Branch

WASHINGTON, D.C.

Report No. 4A-HR-00-11-012

SEPTEMBER 30, 2011

We conducted a performance audit of the Office of Personnel Management's (OPM) Human Resources Solutions' (HRS) Vendor Management Branch (VMB). Our main objective was to determine if the VMB is effectively managing its vendor management operations. Specifically, we performed test work to:

- determine if vendor task orders awarded in fiscal year (FY) 2010 complied with Federal Acquisition Regulations (FAR);
- determine if the VMB's performance measures are reliable in measuring actual performance; and,
- verify if Deliverable Receipt Forms were appropriately approved in FY 2010.

The VMB is responsible for providing Government agencies with customized training and human resource solutions that improve workforce performance at individual, team, and enterprise levels through the activities of pre-competed private sector vendors. VMB partners in this effort with OPM's Facilities, Security, and Contracting (FSC) office. FSC provides VMB with contracting officer personnel to achieve its mission and provide oversight in managing contract bidding and negotiations.

We determined that VMB does not have effective controls in place to ensure:

- Deliverable Receipt Forms are prepared and accepted for tasks completed by its vendors prior to payment, and,
- compliance with the FAR for VMB's contracting processes.

We recommended that FSC and HRS work together to establish controls over these areas.



Special Audits

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

PHARMACY BENEFIT MANAGERS

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

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

Group Health Incorporated's Pharmacy Operations for Contract Year 2009

NEW YORK, NEW YORK

Report No. 1H-80-00-10-062

SEPTEMBER 8, 2011

At the request of the OPM contracting office, we conducted a performance audit of Group Health Incorporated's (GHI) FEHBP 2009 pharmacy operations. The primary objectives of the audit were to: determine GHI's compliance with the regulations and requirements contained in the contract; and, verify whether a special drawdown of \$29 million paid to GHI to cover its pharmacy claim payments from January through September of 2009 was accurate and supported by sufficient documentation.

April 1, 2011 – September 30, 2011



Our audit identified instances where GHI improperly paid pharmacies for prescription drug benefits. As a result, the FEHBP was overcharged \$115,913, which includes \$7,893 for lost investment income. Specifically, we found that GHI:

- processed 358 pharmacy claims, totaling \$53,726, for 30 members age 22 and over whose eligibility could not be verified;
- processed 143 claims, totaling \$29,814, for nutritional supplements without verifying that these drugs were a covered benefit under the FEHBP;
- incorrectly priced 93 claims higher than the agreed-upon price, which cost the FEHBP an additional \$19,252 in 2009;
- paid an FEHBP debarred provider, Better Health Pharmacy Inc., \$3,789 for 97 claims in 2009; and,
- processed 14 claims for 5 members after their termination date and incurred \$1,439 in prescription drug payments during 2009.

The FEHBP is due \$7,893 for lost investment income on improper payments made for 2009 prescription drug benefits.

Because of the difficulties encountered in obtaining requested documentation throughout the audit, we also recommended that OPM's contracting office take the necessary steps to penalize GHI for its inability to meet its contractual requirements.

GHI agreed with five of the six identified issues and is in the process of implementing corrective actions to address them and to ensure that the amounts questioned are returned to the FEHBP.

COMBINED FEDERAL CAMPAIGN

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

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

CFC audits do not identify savings to the Government, because the funds involved are charitable donations made by Federal employees. Our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's Office of CFC Operations works with the auditee to resolve the findings after the final audit report is issued. If the CFC does not comply with the recommendations, the OPM Director can deny the organization's future participation in the CFC.



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 OPM Director to conduct the CFC in a particular community. It organizes the local CFC, determines the eligibility of local charities to participate, supervises the activities of the Principal Combined Fund Organization (PCFO), and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.
- **Principal Combined Fund Organization**
The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. Their duties include collecting and distributing CFC funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.
- **Local Federations**
A local federation is a group of local voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.
- **Independent Organizations**
Independent Organizations are organizations that are not members of a federation for the purposes of the CFC.

During this reporting period, we issued one audit report of a local CFC and one audit report of a CFC National Federation.

Our auditors identified several violations of regulations and guidelines governing local CFC operations. Some of the errors identified include:

- **PCFO Application Missing Required Language**
The PCFO's application did not include specific language required by the regulations.

- **Approval of PCFO Reimbursement of Campaign Expenses**

The LFCC did not approve actual campaign expenses prior to its reimbursement to the PCFO.

- **Campaign Expenses**

The PCFO did not properly match campaign expenses incurred with the related campaign receipts. Additionally, for salary and management fee-related expenses, the PCFO reimbursed itself directly out of CFC funds.

- **Cutoff Procedures Not in Compliance**

The PCFO improperly used January 1st as a cutoff date to allocate CFC receipts to campaigns receiving funds concurrently.

- **Pledge Card Errors**

The PCFO incorrectly input donor release of information data into its pledge card database on five pledge cards. Additionally, the PCFO was unable to provide copies of two pledge cards for review.

- **Eligibility**

The LFCC did not follow the regulations concerning local agency and federation eligibility.

We provided audit findings and recommendations for corrective action to OPM management. As a result of this audit, the campaign ceased its participation in the CFC and merged with another local campaign.

Our audit of the CFC National Federation identified the following violations of regulations and guidelines governing its operations:

- **Expenses Understated in Annual Report**

The CFC National Federation did not accurately report the membership dues and/or service charges received from its member agencies.

- **The CFC National Federation's Local Affiliates Overcharged its Member Agencies**

Three of the eight local affiliates reviewed did not comply with the member agency administrative fee limitation set by the federation's national office. As a result, its member agencies were overcharged \$142,852 in administrative fees.



ENFORCEMENT ACTIVITIES

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$890 billion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over eight million current and retired Federal civilian employees, including eligible family members, and disburse over \$100 billion annually. The majority of our OIG criminal investigative efforts are spent examining potential fraud against these trust funds. However, we also investigate OPM employee misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our office opened 37 criminal investigations and closed 88, with 141 still in progress. Our criminal investigations led to 21 arrests, 26 indictments and informations, 31 convictions and \$5,704,728 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 \$9,215,502 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 29.

HEALTH CARE FRAUD

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

April 1, 2011 – September 30, 2011



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

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

HEALTH CARE FRAUD CASES

FEHBP Recovers \$1.5 Million from UCB, Inc.

This case was based on two *qui tams* filed in Washington, D.C. and Oregon. UCB, Inc. (UCB), a subsidiary of Belgian pharmaceutical manufacturer UCB SA, agreed to pay more than \$34 million to resolve criminal and civil liabilities arising from the illegal promotion of the anti-epileptic drug Keppra.

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

UCB pled guilty to a misdemeanor in connection with the company's misbranding of Keppra, in violation of the Food, Drug, and Cosmetic Act. Keppra was approved by the Food and Drug Administration (FDA) as an anti-epileptic drug, for the treatment of

seizures in adults and children suffering from epilepsy. Keppra is not approved for the treatment of migraine, headache, psychiatric conditions or pain conditions. A manufacturer may not market or promote a drug for any use not specified in the FDA-approved product label.

As a result of the settlement, the FEHBP received \$1,500,277.

This was a joint investigation with the Federal Bureau of Investigations (FBI), the FDA Office of Criminal Investigations, the Department of Veterans Affairs (VA) OIG, Department of Health and Human Services (HHS) OIG, the Department of Labor (DOL) OIG, the Department of Defense (DoD) OIG, and our office.

Physical Therapist Bills for "Ghost Visits"

A physical therapist in New York received over \$2.5 million in reimbursements for procedures allegedly performed by licensed professionals, when those services were actually performed by non-licensed individuals. He also billed for nonexistent appointments or "ghost visits."

During undercover visits, an individual not licensed to perform physical therapy treated a confidential informant (CI) for back and neck pain. The physical therapist performed electro stimulation and massage therapy, and instructed the CI to return for weekly treatments. During a subsequent visit, the CI was instructed to sign a patient log for dates that were billed as visits even though the CI was never at the clinic on the dates billed.

The physical therapist pled guilty to health care fraud and was sentenced to 12 months incarceration, 36 months probation, and 240 hours community service. He was ordered to forfeit \$500,000, pay a \$50,000 fine, and pay \$2,549,977 in restitution.

This was a joint investigation with the FBI, the United States Postal Service (USPS) OIG, the HHS OIG, the DOL OIG, and the OPM OIG.



Phantom Physicians Group Bills for Services Never Rendered

In July 2009, a physician reported to an FEHBP carrier that she received \$30,000 from the FEHBP carrier for services to patients she had not seen. The physician was a victim of identity theft, and a review of the FEHBP carrier's records revealed that the checks were issued as a result of fraudulent claims for services supposedly rendered by a fictitious or "phantom" physicians group. The FEHBP carrier referred the case to our office.

Investigation revealed that the phantom group stole the identities of five medical providers, as well as FEHBP and private insurance member information, in order to bill for services that were never performed.

The five physicians were interviewed by our investigators and all denied that they were part of the phantom group. Additionally, all of the physicians denied lending their provider number to anyone, including to the defendant, who listed himself as the group's president.

Numerous FEHBP and private insurance members were interviewed and all denied receiving services billed by the phantom physicians group. From March 2009 through November 2009, the phantom physicians group billed a total of \$565,521 for services that were never rendered.

In February 2011, a five count indictment was issued for the defendant for violations of health care fraud. Our investigators attempted to serve an arrest warrant on the defendant, who could not be located and was placed in fugitive status.

In May 2011, the defendant attempted to leave the Miami International Airport on a flight headed to Havana, Cuba. While at the ticketing counter, the airline agent questioned the defendant regarding his alien status. The defendant panicked, dropped his passport and luggage, and fled the airport. Later that day, he turned himself in to a local police station where he was interviewed by our investigators. The defendant admitted that he was fleeing the United States to Cuba with no intention of returning.

In June 2011, the defendant pled guilty to one count of health care fraud. In September 2011, the defendant was sentenced to 18 months incarceration, 3 years of supervised release, and ordered to pay \$112,113 in restitution, of which OPM received \$44,906.

This was a joint investigation with the FBI and our office.

FEHBP Recovers \$800,250 from Serono Laboratories Settlement

In May 2011, pharmaceutical manufacturer Serono Laboratories, Inc. (Serono) entered into a settlement agreement with the Government, agreeing to pay \$44.3 million to resolve False Claims Act allegations in connection with the marketing of one of its popular drugs, Rebif. The settlement resolves allegations that Serono paid health care providers from the launch of Rebif in January 2002 through December 2009, to induce them to promote or prescribe Rebif. Rebif is an injectable drug used to treat multiple sclerosis.

The Government alleged that Serono bribed physicians to write prescriptions for Rebif. These bribes resulted in the submission of false claims to various Federal health care programs for Rebif prescriptions and promotions. They persuaded physicians to prescribe Rebif and offered kickbacks in the form of:

- promotional speaking engagements;
- speaker's training and advisory and consultant meetings;
- claiming expense reimbursements;
- applying for independent medical and educational grants;
- granting sponsorships; and,
- providing charitable contributions.



In the Department of Justice press release, Rod J. Rosenstein, U.S. Attorney for the District of Maryland, stated, “Health care decisions must be based solely upon what is best for the individual patient and not on which pharmaceutical company is paying the doctor the biggest kickback. All consumers have the right to know that their health care provider’s judgment about medications they should take has not been undermined by kickbacks from pharmaceutical manufacturers.”

Although the FEHBP is excluded from the Anti-Kickback Statute, in this case the Government was able to negotiate single common law damages for the FEHBP in the amount of \$800,250. Unlike the FEHBP, other Federal programs included in the settlement were not limited to single damages. This case highlights why the FEHBP should be included in the Anti-Kickback Statute (Title 42 United States Code Section 1320a-7b). Federal employees deserve health care untainted by bribes and kickbacks.

This case was investigated by the HHS OIG, the DoD OIG, and the OPM OIG.

Physician Submits False Claims for Cancer Drugs

This case originated from a *qui tam* in California against a licensed oncologist and the owner of the Hematology and Oncology Medical Group, Inc. This *qui tam* alleges that the group knowingly falsified medical records, altered medical data and laboratory results, and submitted inaccurate and false billing records to the Government.

From 2004 to 2009, the oncologist devised and executed a scheme to defraud federally funded and private health benefit programs. The oncologist submitted fraudulent claims to the Government for various medications relating to cancer treatment. These drugs included Neulasta, Neupogen, Procrit, Epogen, Aranesp, and Neumega. He billed for medications he did not provide his patients, and also billed for more expensive medications when less expensive ones were available. Although his staff advised against this practice, the oncologist continued this fraudulent activity.

In July 2011, the oncologist was sentenced to 18 months incarceration for health care fraud with 36 months of supervised release. He was also ordered to pay a \$500 fine and \$1,004,689 in restitution.

This case was investigated by the FBI, the HHS OIG, and our office.

RETIREMENT FRAUD

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

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

RETIREMENT FRAUD CASES

OPM Manager Swindles Retirement System

Due to internal safeguards put into place by OPM after a 2004 employee theft and embezzlement case investigated by our office, OPM’s Retirement Services’ Quality Assurance Group promptly detected and referred to the OIG an alleged theft by a senior manager in Retirement Operations.

Our investigation revealed that the manager was able to arrange for and successfully complete five separate unauthorized payments from the OPM Retirement Operations office. Due to this manager’s position and responsibilities, he had the ability to authorize annuity payments. This allowed him to make payments, from



April to August 2010, to his personal bank account using the identity of legitimate Federal retirees with the same name as his.

The manager confessed to using his knowledge of and user access to the OPM retirement system to authorize payments for legitimate retirees, but redirected the payments to his personal checking account.

In February 2011, the manager pled guilty to theft of public money. In June 2011, he was sentenced to 6 months home detention, 100 hours community service, 60 months probation and ordered to pay full restitution of \$40,389 to OPM. He also resigned from his position with OPM.

Son Pleads Guilty to Theft of Public Money

Through a computer match conducted between OPM's active annuity rolls and SSA's death records, OPM determined that a Federal annuitant died in January 1997. Because OPM was never notified of the annuitant's death, the annuity payments continued, resulting in an overpayment of \$162,128.

Our investigation revealed that the Federal annuitant and his son held a joint bank account where the monthly annuity payments were deposited. The surviving son did not notify OPM of his father's death and continued to convert the funds for his own personal use.

Our investigators interviewed the son, who had a prior criminal record for drug possession, manufacturing and distribution of illegal drugs, and theft by deception. During the interview, the son admitted to spending his father's annuity payments and forging his father's name on OPM's address verification letters. The son stated that because he was under the influence of drugs he did not know what he was signing.

In March 2011, the son pled guilty to embezzlement and theft of public money and was sentenced in June 2011. He was sentenced to 24 months incarceration and 3 years of supervised release. Additionally, he was ordered to pay \$162,128 in restitution to OPM.

Daughter Uses Deceased Mother's Driver's License to Cash Retirement Checks

In May 2010, we received allegations that a Federal survivor annuitant died in 1999 and OPM was never notified of the survivor annuitant's death. In addition, OPM received false statements in the form of address verification letters attesting that the annuitant was alive. The monthly checks continued to be issued until December 2009, which resulted in an overpayment of \$100,872.

Our investigators determined that all payments to the deceased survivor annuitant were mailed to an address belonging to her daughter. Additionally, OPM mailed address verification letters which were returned to OPM bearing the alleged signature of the survivor annuitant.

In August 2010, our investigators interviewed the daughter who admitted to cashing her mother's checks at a local liquor store where she forged her mother's signature on the checks. She confessed that she had a copy of her mother's driver's license which she used as identification at the store in order to cash her mother's checks.

In April 2011, the daughter pled guilty to theft of public money.

In September 2011, the daughter was sentenced to 10 months incarceration, 3 years supervised release, and ordered to pay \$100,872 in restitution to OPM.

Deceased Annuitant's Daughter-in-Law Steals OPM Annuity and SSA Benefits

We initiated this investigation in April 2010, after receiving allegations that a deceased Federal annuitant's daughter-in-law fraudulently obtained retirement payments from OPM. OPM was never notified of the annuitant's death in April 2000.

The daughter-in-law received \$149,348 in improper benefits from OPM. In addition, the daughter-in-law



also continued receiving SSA benefits intended for her mother-in-law following her death. The Social Security benefits paid post-death totaled \$74,108.

Additionally, OPM mailed two address verification letters that were returned bearing the alleged signature of the annuitant after her death.

In January 2011, the daughter-in-law pled guilty to theft of public money. In May 2011, she was sentenced to 24 months in prison, 36 months supervised release, and ordered to pay full restitution to OPM and SSA in the amount of \$223,456, with OPM receiving \$149,348.

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

Son Steals Deceased Father's Annuity Payments

We received a referral from a deceased annuitant's financial institution, which reported that annuity payments continued to be deposited into the deceased annuitant's account.

The annuitant died in October 1990. OPM annuity and VA benefit payments intended for the annuitant were sent by electronic funds transfer to a joint bank account shared by the annuitant and his son. OPM annuity payments continued to be deposited into the annuitant's account until July 2009, resulting in an overpayment of \$294,854.

Investigators determined that the annuitant died in Canada and coordinated with the Royal Canadian Mounted Police to obtain the death certificate.

In November 2010, the son confessed to the theft and to using the money for living expenses. In June 2011, the son was sentenced to 12 months house arrest and ordered to pay total restitution of \$342,142, of which OPM received \$294,854.

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

Deceased Annuitant's Son Sentenced for Forgery

Through a computer match conducted between OPM's active annuity rolls and the SSA's death records, OPM determined that a retired Federal annuitant died in March 1992. However, benefits continued to be paid after his death resulting in an overpayment of \$335,882 over a course of 17 years.

Shortly after his death, OPM determined that the annuitant was deceased and stopped payments. The son immediately called OPM, pretended to be his father and claimed to be alive, which resulted in the reinstatement of benefits.

Our investigators interviewed the annuitant's son who admitted to impersonating his father by forging his signature on OPM documents, including three address verification letters, and redirecting the annuity payments to various personal bank accounts. He also admitted to canceling his father's health benefits in order to increase the amount of the annuity payments.

In September 2010, the son pled guilty to theft of public money. In June 2011, he was sentenced to 18 months incarceration, 2 years supervised release, 500 hours community service, and ordered to pay full restitution of \$335,882 to OPM.

Son Conceals Father's Death and Collects Over \$134,000 in Annuity Payments

A death match conducted with the SSA revealed that a retired Federal annuitant died in April 1991. Since OPM was never notified, the annuity payments continued resulting in an overpayment of \$134,640.

Our investigators determined that the son forged his deceased father's signature on three address verification letters, falsely certifying that his father was still alive. Based on these falsifications, OPM continued to pay annuity benefits. In addition, in order to collect his father's annuity payments, the son created a false identity and opened a joint bank account using a fraudulent Pennsylvania driver's license with his photograph.



In April 2011, the son pled guilty to theft of public money. In July 2011, he was sentenced to 6 months incarceration, 36 months probation, 6 months home detention, and ordered to pay full restitution to OPM in the amount of \$134,640.

REVOLVING FUND INVESTIGATIONS

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

OPM's Federal Investigative Services (FIS) conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts approximately 90 percent of all personnel background investigations for the Federal Government. With a staff of over 9,200 Federal and contract employees, FIS processed over 2.1 million investigations in FY 2011. Federal agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

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

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

Former OPM Background Investigator Sentenced

In our semiannual report ending March 2011, we reported that a background investigator pled guilty to making false statements related to over two dozen background investigations.

Due to these false representations, FIS was required to reopen and rework the background investigations that were assigned to the background investigator, costing OPM an estimated \$106,712.

In June 2011, he was sentenced to 90 days incarceration with 3 years supervised release, 180 days home detention and 400 hours community service. He was also ordered to pay \$106,712 in restitution to OPM.

Former OPM Employee Charged with Falsifying Records

The OIG received an allegation from OPM FIS, Integrity Assurance office regarding the misconduct of a background investigator who made false statements in the performance of her job. Between March 2009 and March 2010, in more than a dozen background investigations, the investigator represented that she interviewed a source or reviewed a record regarding the subject of the background investigation when, in fact, she had not.

Federal agencies rely on the results of these background investigations to determine whether the applicants are suitable for positions having access to classified information, impacting national security, or receiving or retaining security clearances.

Due to these false representations, FIS was required to reopen and reinvestigate the casework that was assigned to the background investigator, which cost OPM an estimated \$73,294.

In April 2011, the background investigator pled guilty to making a false statement. In July 2011, she was sentenced to 4 months incarceration, 150 days home detention and 50 hours community service. The judge also ordered her to pay \$73,294 in restitution.

After completing the 4 months of incarceration, she will be placed on 30 months of supervised release.



Violation of Personnel Regulation at the Federal Executive Institute

An administrative investigation revealed that a GS-15 on a temporary appointment was detailed to a Senior Executive Service (SES) position at the Federal Executive Institute (FEI) for 609 days. This far exceeded the 240-day regulatory limit on non-competitive details of non-SES members to SES positions established by Title 5, Code of Federal Regulations, Section 317.903 (b) (3), a regulation which OPM authored and is responsible for enforcing.

A senior agency official submitted a request to extend the original short-term detail, and failed to advise the approving official of the regulatory requirements for granting an extension. As established by Title 5, Code of Federal Regulations, Section 317.903 (b) (3), an agency must use competitive procedures when detailing a non-SES employee to an SES position for more than 240 days unless the employee is eligible for a noncompetitive career SES appointment.

The OIG issued a report of its findings to the OPM Director. The individual was not selected for the position. Both the detailed employee and the senior agency official who arranged his detail assignment to FEI have since left OPM.

OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's Health Care Fraud Hotline, Retirement and Special Investigations Hotline, online anonymous complaint form, and mailed-in complaints also contribute to identifying fraud and abuse. We received 482 formal complaints and telephone calls on these hotlines during the reporting period. The table on page 29 reports the activities of each hotline.

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

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

Retirement Fraud and Special Investigations Hotline

The Retirement Fraud and Special Investigations Hotline provides a method for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 275 contacts, including telephone calls, emails, letters, and referrals from other agencies.

Health Care Fraud Hotline

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

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

The Health Care Fraud Hotline received 207 complaints during this reporting period, including telephone calls, emails, and letters.

OIG-Initiated Complaints

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

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

Correction of Prior Period Semiannual Report

In our semiannual report for the period ending March 31, 2011, we underreported \$665,128 involving two health care and three retirement investigations. These investigations resulted in civil settlements where notification of the final settlement recoveries was delayed.



Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 31,608 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 368 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 2,640 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.*

Virginia Provider Debarred for Participating in Health Care Fraud Conspiracy

Based on research and analysis of electronically available information, we identified a health care provider who was convicted of one count of health care fraud, 26 counts of false statements, and one count of alteration of records to obstruct an investigation. He participated in a conspiracy to defraud the FEHBP as a medical practitioner and surgeon.

From March 2006 to August 2008, the provider misrepresented patients' diagnoses and billed for more costly examinations than actually provided in order to receive higher payments from health care programs. The provider also falsified claims indicating that he administered certain amounts of chemotherapy drugs and other prescriptions when these dosages were not actually administered.



In March 2010, he was sentenced to 63 months of imprisonment and three years of supervised release. In addition, he was ordered to pay restitution in the amount of \$790,642.

The conviction constitutes a mandatory basis for debarment under the FEHBP's administrative sanctions authority. We imposed an eight year debarment based on aggravating factors associated with his offenses, including the monetary loss to the FEHBP carriers and the prolonged period during which he knowingly submitted false claims.

Virginia Physician and Practice Debarred for Loss of Medical License

Based on a joint referral from our Office of Investigations and an FEHBP carrier, we debarred a Virginia physician and her pain management practice in August 2011. Our debarment was based on the Virginia Board of Medicine's revocation of the physician's medical license. The physician was cited for providing a consistent pattern of sub-standard care in the monitoring and management of patients being treated for chronic pain, placing the patients' health and safety at risk.

Some of the physician's specific offenses included:

- prescribing addictive pain narcotics to patients without performing a complete physical examination;
- not requesting or retaining patients' comprehensive medical history (including substance abuse or mental illness history);
- prescribing medicines to patients who exhibited "drug seeking" behavior or signs or symptoms that they were abusing or misusing the medications being prescribed; and,
- prescribing medications to patients that were inadvisable or potentially dangerous.

Our debarment of the physician and practice is for an indefinite period pending resolution of the physician's Virginia medical licensure.

Maryland Physician Debarred for Unprofessional Conduct

Based on research and analysis of electronically available information, we debarred a Maryland internal medicine physician in September 2011. Our debarment was based on the Maryland Board of Physicians (MBP) revocation of the physician's medical license.

The MBP initially suspended the physician's license subsequent to the Drug Enforcement Agency's (DEA) notification that they were conducting an investigation on the physician for allegations of excessive prescribing of controlled substances, selling prescriptions and personal drug abuse by the physician. The physician participated in the FEHBP as a provider of medical services.

During the investigation, family members, including the physician's wife, revealed that the physician routinely wrote prescriptions for controlled substances for them that they filled and then gave to the physician for his personal use. This information provided the MBP justification to believe that the physician was in violation of a June 2007 consent order prohibiting the physician from prescribing medications to members of his family and using mood altering and controlled substances unless prescribed for legitimate purposes.

Following the investigation, the MBP revoked the physician's license and determined that the physician was:

- guilty of immoral or unprofessional conduct in the practice of medicine;
- professionally, physically, or mentally incompetent;
- addicted to, or habitually abused narcotic or controlled dangerous substances;
- providing professional services while using narcotics or controlled substances; and,
- selling, prescribing, giving away or administering drugs for illegal or illegitimate medical purposes.

Federal regulations state that the OPM 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 resolution of the physician's Maryland medical licensure.



LEGAL ACTIVITIES

Legislative Proposals

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

During this reporting period, the OIG has developed two legislative proposals: one that would increase OIG oversight of OPM's self-funding programs and another that would enhance our office's capability to fight fraud, waste, and abuse in the FEHBP. Representatives from the OIG have worked with Congressional staff on these issues and have briefed them on these proposals. The OPM Director has indicated his support for both of these initiatives.

OIG OVERSIGHT OF OPM'S SELF-FUNDING PROGRAMS

OPM administers several programs through which it provides goods and services to other Federal agencies on a reimbursable basis. Because these programs are essentially commercial in nature, OPM must price the goods and services in a manner that allows it to recover the "actual cost" or the "administrative costs," depending on the program, that the agency incurs in providing these goods and services. OPM's self-funding programs include the activities funded by OPM's Revolving Fund, specifically FIS, HRS, the Federal Long Term Care Insurance Program (FLTCIP), and the Federal Employee Dental and Vision Insurance Program (FEDVIP).

These programs need more oversight than the OIG can currently provide given its resource structure. FIS and HRS alone comprise an approximately \$2 billion a year "business." Through FIS, OPM conducts 90 percent of the Federal Government's background checks of Federal employees and potential employees, including persons who work at nuclear power plants, security guards working at Federal buildings, etc. Since 2007, there have been 14 convictions of FIS background investigators resulting from OIG investigations of fabrication of these background checks. HRS provides training and other human resources services to every agency in the Federal Government and has entered into over 10,000 contracts to provide these services. Given the size and intergovernmental nature of these programs, it is essential that OIG oversight of them be increased.

April 1, 2011 – September 30, 2011



Our legislative initiative would address the concerns regarding lack of oversight by enforcing the statutory mandate that these programs be self-funding. Currently, these programs are statutorily required to operate without additional annual appropriations, but they are nonetheless being subsidized because OIG's appropriated funds are being used to pay for their oversight. Our proposal would amend the terms "actual cost" and "administrative costs" as used in the statutes which established the self-funding mechanisms for the RF programs, FLTCIP, and FEDVIP to specifically include the costs of OIG oversight as a category of expense to be recovered through program operations. OIG in turn would receive funding for its oversight of those programs from the RF and the FLTCIP and FEDVIP administrative accounts.

HEALTH CARE ANTI-FRAUD INITIATIVE

FEHBP Anti-Fraud Program

There are two parts to this proposed initiative. First, the OIG proposes that an FEHBP Anti-Fraud Program (FAFP) be established. This program would be focused on developing innovative new approaches to addressing fraud and abuse within the FEHBP, as well as expanding the scope of the investigative work related to such crimes. FAFP would help provide OIG and OPM the tools necessary to craft such approaches. It would be generally analogous to the anti-fraud fund that was established by the Health Insurance Portability and Accountability Act (HIPAA) for use by the Department of Justice and the Office of the Inspector General of the Department of Health and Human Services to combat health care fraud.

FAFP would be funded by a portion of the recoveries obtained in judicial cases involving fraud against the FEHBP. In such cases, the U.S. Government often receives not only the amount defrauded under the program, but also additional funds, such as civil monetary penalties, criminal fines, and False Claims Act settlements. Currently these additional recoveries are paid into the Treasury's general fund under the miscellaneous receipts statute. The OIG proposal would authorize a portion of such recoveries to be retained by OPM and OIG for purposes of funding FAFP activities. The result would be that those who defraud the FEHBP would pay to prevent the very crimes that they themselves committed.

Amendment of the Anti-Kickback Statute

The second component of the Health Care Anti-Fraud Initiative would amend the Federal Anti-Kickback Statute, 42 U.S.C. §§ 1320a-7b, to include the FEHBP in the definition of a "Federal health care program". This statute makes it illegal for health care providers, including doctors, to knowingly and willfully accept bribes or other payment in return for generating business in any Federal health care program – except the FEHBP.

The FEHBP and Federal enrollees need the protection of the Anti-Kickback Statute—which is intended to ensure that medical decisions are based on patient needs rather than providers' personal gain—just as much as other Federal health care programs and their enrollees do. Furthermore, kickbacks contribute to driving up the already rising costs of health care. Federal tax dollars are used in the FEHBP just as they are in other health care programs, and Federal employees as patients are indistinguishable from participants in other Federal health care programs. Thus, is no reasonable justification for excluding the FEHBP from coverage under the anti-kickback law.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

JUDICIAL ACTIONS:

Arrests	21
Indictments and Informations	26
Convictions	31

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$5,704,728
Fines, Penalties, Assessments, and Forfeitures	\$9,215,502 ¹

RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	19
Referred to:	
OPM Program Offices	163
Other Federal Agencies	93
Total	275

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	32
Referred to:	
OPM Program Offices	40
Other Federal/State Agencies	27
FEHBP Insurance Carriers or Providers	108
Total	207
Total Hotline Contacts and Complaint Activity	482

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	368
Health Care Provider Debarment and Suspension Inquiries	2,640
Debarments and Suspensions in Effect at End of Reporting Period	31,608

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

APPENDICES



APPENDIX I Final Reports Issued With Questioned Costs for Insurance Programs APRIL 1, 2011 TO SEPTEMBER 30, 2011

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$ 6,948,641
B. Reports issued during the reporting period with findings	12	47,024,794
Subtotals (A+B)	17	53,973,435
C. Reports for which a management decision was made during the reporting period:	12	44,235,673
1. Disallowed costs	N/A	42,229,973
2. Costs not disallowed	N/A	2,005,700
D. Reports for which no management decision has been made by the end of the reporting period	5	9,737,762
E. Reports for which no management decision has been made within 6 months of issuance	0	0

April 1, 2011 – September 30, 2011



APPENDIX II – A
Final Reports Issued with Recommendations
for All Other Audit Entities
 APRIL 1, 2011 TO SEPTEMBER 30, 2011

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	\$ 39,817
B. Reports issued during the reporting period with findings	1	142,852
Subtotals (A+B)	5	175,669
C. Reports for which a management decision was made during the reporting period:	3	143,957
1. Disallowed costs	N/A	143,957
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	38,712
E. Reports for which no management decision has been made within 6 months of issuance	0	0

APPENDIX II – B
Final Reports Issued with Recommendations
for Better Use of Funds
 APRIL 1, 2011 TO SEPTEMBER 30, 2011

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	0	\$ 0
B. Reports issued during the reporting period with findings	1	120,000,000
Subtotals (A+B)	1	120,000,000
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX III

Insurance Audit Reports Issued

APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued	Questioned Costs
1C-2U-00-11-003	Aetna Open Access of Georgia in Blue Bell, Pennsylvania	April 13, 2011	\$ 1,487,355
1C-ZJ-00-10-056	Humana Health Plans of Puerto Rico, Inc. in San Juan, Puerto Rico	April 13, 2011	208,502
1A-10-41-10-012	BlueCross BlueShield of Florida in Jacksonville, Florida	May 12, 2011	21,425,283
1A-10-39-10-011	WellPoint, Inc. in Mason, Ohio	May 13, 2011	4,840,701
1D-9R-00-11-001	Optima Health Plan in Virginia Beach, Virginia	May 18, 2011	179,778
1A-99-00-10-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	June 8, 2011	7,742,389
1C-K9-00-11-020	PacifiCare of Nevada in Cypress, California	June 8, 2011	0
1C-MM-00-10-059	Group Health Plan, Inc. in St. Louis, Missouri	June 16, 2011	189,691
1C-MJ-00-11-025	Humana, Inc. of Tampa in Louisville, Kentucky	June 22, 2011	0
1C-EA-00-11-056	Capital Health Plan Proposed Rate Reconciliation in Tallahassee, Florida	July 21, 2011	0
1C-GA-00-11-049	MVP Health Care – Eastern Proposed Rate Reconciliation in Schenectady, New York	July 25, 2011	0
1C-ED-00-10-053	Keystone Health Plan East, Inc. in Philadelphia, Pennsylvania	July 25, 2011	2,168,423
1C-8W-00-11-007	UPMC Health Plan in Pittsburgh, Pennsylvania	July 27, 2011	0
1C-M9-00-11-048	MVP Health Care – Central Proposed Rate Reconciliation in Schenectady, New York	July 27, 2011	0
1C-U4-00-11-054	Health Plan of the Upper Ohio Valley Proposed Rate Reconciliation in St. Clairsville, Ohio	July 27, 2011	0
1C-51-00-11-053	Health Insurance Plan of New York Proposed Rate Reconciliation in New York, New York	July 27, 2011	0
1D-80-00-10-046	Group Health Incorporated in New York, New York	July 27, 2011	3,690,192

April 1, 2011 – September 30, 2011



APPENDIX III
Insurance Audit Reports Issued
 APRIL 1, 2011 TO SEPTEMBER 30, 2011
(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-IM-00-11-026	Global Health, Inc. in Oklahoma City, Oklahoma	August 17, 2011	\$ 0
1B-47-00-11-002	American Postal Workers Union Health Plan in Glen Burnie, Maryland	September 1, 2011	19,956
1H-80-00-10-062	Group Health Incorporated's Pharmacy Operations for Contract Year 2009 in New York, New York	September 8, 2011	115,913
1A-99-00-10-061	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.	September 8, 2011	4,956,611
1C-UB-00-11-032	Aetna Open Access in Memphis, Tennessee	September 28, 2011	0
1C-ML-00-11-004	AvMed Health Plan in Gainesville, Florida	September 30, 2011	0
TOTALS			\$47,024,794

APPENDIX IV
Internal Audit Reports Issued
 APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued
4A-HR-00-11-012	OPM's Human Resource Solutions' Vendor Management Branch in Washington, D.C.	September 30, 2011

APPENDIX V
Combined Federal Campaign Audit Reports Issued
 APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued
3A-CF-00-10-036	The 2008 Combined Federal Campaign Activities of Community Health Charities in Arlington, Virginia	April 4, 2011
3A-CF-00-10-032	The 2007 and 2008 Wiregrass Area Combined Federal Campaigns in Dothan, Alabama	June 16, 2011



APPENDIX VI Information Systems Audit Reports Issued

APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued
4A-CI-00-11-016	Information Technology Security Controls of OPM's Enterprise Server Infrastructure General Support System in Washington, D.C.	May 16, 2011
4A-HR-00-11-017	Information Technology Security Controls of OPM's Presidential Management Fellows System in Washington, D.C.	May 16, 2011
1H-01-00-10-057	Information Systems General and Application Controls at CVS Caremark in Scottsdale, Arizona and Northbrook, Illinois	May 17, 2011
4A-CF-00-11-015	Information Technology Security Controls of OPM's Consolidated Business Information System in Washington, D.C.	June 1, 2011
1B-47-00-11-044	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland	June 27, 2011
4A-CI-00-11-043	Information Technology Security Controls of OPM's Center for Talent Services General Support System in Washington, D.C.	September 28, 2011

APPENDIX VII Evaluation Reports Issued

APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued	Funds Put to Better Use
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.	September 14, 2011	\$120,000,000 ²
TOTALS			\$120,000,000

²This amount represents cost savings that would be repeated annually.

April 1, 2011 – September 30, 2011



APPENDIX VIII

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

APRIL 1, 2011 TO SEPTEMBER 30, 2011

Report Number	Subject	Date Issued
4A-IS-00-05-026	Information Technology Security Controls of OPM's Electronic Questionnaire for Investigative Processing; 20 total recommendations; 1 open recommendation	June 16, 2005
4A-CI-00-07-015	The Privacy Program at OPM; 7 total recommendations; 1 open recommendation	January 25, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM; 12 total recommendations; 8 open recommendations	April 16, 2007
1C-3U-00-05-085	UnitedHealthcare of Ohio, Inc. in West Chester, Ohio; 2 total recommendations; 2 open recommendations	January 18, 2008
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 2 open recommendations	March 18, 2008
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana; 2 total recommendations; 2 open recommendations	June 12, 2008
1C-6Q-00-07-029	Universal Care, Inc. of California in Signal Hill, California; 2 total recommendations; 2 open recommendations	September 15, 2008
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008; 19 total recommendations; 3 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements; 6 total recommendations; 6 open recommendations	November 14, 2008
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 16 total recommendations; 6 open recommendations	March 26, 2009
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	June 23, 2009
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	July 20, 2009
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	October 14, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009; 30 total recommendations; 8 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements; 5 total recommendations; 5 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System; 8 total recommendations; 8 open recommendations	January 8, 2010



APPENDIX VIII

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

APRIL 1, 2011 TO SEPTEMBER 30, 2011

(Continued)

Report Number	Subject	Date Issued
1A-10-49-09-025	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey; 24 total recommendations; 1 open recommendation	February 12, 2010
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2010
1A-99-00-10-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	March 31, 2010
1B-45-00-09-062	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 6 total recommendations; 5 open recommendations	April 14, 2010
1A-10-85-09-023	CareFirst BlueCross BlueShield in Owings Mill, Maryland; 18 total recommendations; 9 open recommendations	May 21, 2010
1A-10-41-09-063	Information Systems General and Application Controls at BlueCross BlueShield of Florida in Jacksonville, Florida; 5 total recommendations; 2 open recommendations	May 21, 2010
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 6 open recommendations	June 22, 2010
1A-99-00-09-046	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	July 19, 2010
1C-54-00-09-048	Group Health Cooperative in Seattle, Washington; 4 total recommendations; 4 open recommendations	September 8, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System in Washington, D.C.; 15 total recommendations; 1 open recommendation	September 10, 2010
1C-Q1-00-10-026	Lovelace Health Plan in Albuquerque, New Mexico; 2 total recommendations; 2 open recommendations	September 27, 2010
4A-RI-00-10-014	OPM's Court Ordered Benefits Branch in Washington, D.C.; 7 total recommendations; 5 open recommendations	October 14, 2010
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 16 open recommendations	November 10, 2010

April 1, 2011 – September 30, 2011



APPENDIX VIII

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

APRIL 1, 2011 TO SEPTEMBER 30, 2011

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-10-047	Information Technology Security Controls for OPM's Annuity Roll System in Washington, D.C.; 13 total recommendations; 8 open recommendations	November 22, 2010
1B-45-00-10-017	Information Systems General and Application Controls at Coventry Health Care in Scottsdale, Arizona; 15 total recommendations; 5 open recommendations	December 14, 2010
1C-J8-00-10-025	JMH Health Plan in Miami, Florida; 2 total recommendations; 2 open recommendations	December 15, 2010
4A-CF-00-10-043	OPM's Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 7 open recommendations	March 4, 2011
1K-RS-00-11-034	Payroll Functions Related to FEHBP Enrollment Transactions for Annuitants in Washington, D.C.; 5 total recommendations; 5 open recommendations	March 14, 2011
1A-99-00-10-013	WellPoint, Inc. in Mason, Ohio; 10 total recommendations; 5 open recommendations	March 17, 2011
4A-CF-00-10-023	OPM's Invoice Payment Process in Washington, D.C.; 3 total recommendations; 3 open recommendations	March 30, 2011



APPENDIX IX

Most Recent Peer Review Results

APRIL 1, 2011 TO SEPTEMBER 30, 2011

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

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

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



APPENDIX X

Investigative Recoveries

APRIL 1, 2011 TO SEPTEMBER 30, 2011

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
C 2008 00002	Health Care Fraud	Civil	\$ 127,892	\$65,000,000	\$ -
I 2005 00109	Health Care Fraud	Criminal	-	-	20,100
I 2006 00066	Health Care Fraud	Criminal	-	1,004,689	500
I 2007 00020	Health Care Fraud	Civil	23,441	23,441	-
I 2007 00035	Health Care Fraud	Civil	4,710	2,726,420	-
I 2007 00079	Health Care Fraud	Criminal	4,653	55,421	5,050
I 2007 00079	Health Care Fraud	Criminal	4,653	55,421	5,050
I 2008 00033	Retirement Fraud	Criminal	28,337	28,337	-
I 2008 00057	Retirement Fraud	Criminal	36,868	47,409	-
I 2008 00093	Health Care Fraud	Criminal	-	-	500,000
I 2008 00093	Health Care Fraud	Criminal	186,738	2,549,977	50,100
I 2009 00067	Health Care Fraud	Criminal	-	-	1,078,894
I 2009 00067	Health Care Fraud	Criminal	-	-	7,552,383
I 2009 00067	Health Care Fraud	Civil	1,500,277	25,764,530	-
I 2009 00124	Retirement Fraud	Criminal	281,820	281,820	100
I 2010 00007	Retirement Fraud	Criminal	162,128	162,128	100
I 2010 00012	Health Care Fraud	Civil	-	995,000	-
I 2010 00026	Health Care Fraud	Criminal	44,906	112,113	100
I 2010 00033	Retirement Fraud	Criminal	228,949	228,949	1,700
I 2010 00034	Retirement Fraud	Criminal	294,854	342,142	100
I 2010 00036	Retirement Fraud	Criminal	55,441	55,441	100
I 2010 00055	Retirement Fraud	Criminal	59,550	59,550	-
I 2010 00056	Employee/Contractor Misconduct	Criminal	106,712	106,712	100
I 2010 00058	Retirement Fraud	Criminal	126,764	126,764	100
I 2010 00060	Health Care Fraud	Civil	800,250	44,300,000	-
I 2010 00072	Retirement Fraud	Criminal	100,872	110,171	100
I 2010 00077	Retirement Fraud	Criminal	89,856	89,856	-
I 2010 00081	Retirement Fraud	Criminal	40,399	40,399	100
I 2010 00082	Retirement Fraud	Criminal	335,882	335,882	100
I 2010 00088	Retirement Fraud	Criminal	50,174	50,174	-



APPENDIX X

Investigative Recoveries

APRIL 1, 2011 TO SEPTEMBER 30, 2011

(Continued)

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2010 00094	Employee/Contractor Misconduct	Criminal	\$ 73,294	\$ 73,294	\$ –
I 2010 00094	Employee/Contractor Misconduct	Criminal	–	–	100
I 2010 00106	Health Care Fraud	Criminal	–	13,786	–
I 2011 00002	Retirement Fraud	Criminal	116,926	116,926	25
I 2011 00009	Retirement Fraud	Criminal	40,524	40,524	–
I 2011 00010	Employee/Contractor Misconduct	Criminal	–	97,470	100
I 2011 00016	Retirement Fraud	Criminal	149,348	223,456	200
I 2011 00017	Retirement Fraud	Civil	71,819	71,819	–
I 2011 00018	Health Care Fraud	Civil	1,693	225,209	–
I 2011 00022	Retirement Fraud	Criminal	134,640	134,640	100
I 2011 00031	Retirement Fraud	Criminal	134,050	134,050	100
I 2011 00037	Health Care Fraud	Civil	148,025	5,752,194	–
I 2011 00052	Retirement Fraud	Criminal	90,879	90,879	–
I 2011 00067	Health Care Fraud	Civil	1,832	1,889	–
I 2011 00067	Health Care Fraud	Civil	5,183	5,343	–
IA 2010 00008	Retirement Fraud	Criminal	40,389	40,389	100
GRAND TOTAL			\$5,704,728	\$151,674,614	\$9,215,502

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

April 1, 2011 – September 30, 2011



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

	<i>Page</i>
Section 4 (a) (2):	Review of legislation and regulations 27-28
Section 5 (a) (1):	Significant problems, abuses, and deficiencies 1-26
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies 1-15
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed No Activity
Section 5 (a) (4):	Matters referred to prosecutive authorities 17-26
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period. No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period 33-35
Section 5 (a) (7):	Summary of particularly significant reports 2-26
Section 5 (a) (8):	Audit reports containing questioned costs 31-34
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds 32
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period. 36-38
Section 5 (a) (11):	Significant revised management decisions during this reporting period. No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period. No Activity
Section 5 (a) (14) (A):	Peer reviews conducted by another OIG 39
Section 5 (a) (16):	Peer reviews conducted by the OPM OIG. 39



OIG HOTLINE

Report Fraud, Waste or Abuse to the Inspector General

Please Call the HOTLINE:

202-606-2423

Caller can remain anonymous • Information is confidential

<http://www.opm.gov/oig/html/hotline.asp>



MAILING ADDRESS:

OFFICE OF THE INSPECTOR GENERAL
U.S. Office of Personnel Management

Theodore Roosevelt Building
1900 E Street, N.W.
Room 6400
Washington, DC 20415-1100



Office of the Inspector General

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Theodore Roosevelt Building

1900 E Street, N.W., Room 6400, Washington, DC 20415-1100

Telephone: (202) 606-1200

Fax: (202) 606-2153

SEPTEMBER 2011

OIG-SAR-45

www.opm.gov/oig

