

Office of the Inspector General

SEMIANNUAL REPORT

TO

CONGRESS

April 1, 2008 – September 30, 2008



UNITED STATES OFFICE OF PERSONNEL MANAGEMENT



OFFICE OF THE INSPECTOR GENERAL



PRODUCTIVITY INDICATORS

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds.	\$44,137,286
Management Commitments to Recover Funds.	\$43,171,573
Recoveries Through Investigative Actions.	\$17,355,792

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.	51
Investigative Cases Closed.	114
Indictments and Informations.	24
Arrests	25
Convictions	22
Hotline Contacts and Complaint Activity	579
Health Care Provider Debarments and Suspensions.	498
Health Care Provider Debarment and Suspension Inquiries	1,978

Office of the Inspector General



SEMIANNUAL REPORT TO CONGRESS

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**UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT**



THE INSPECTOR GENERAL'S MESSAGE

John Quincy Adams once said, “Patience and perseverance have a magical effect before which difficulties disappear and obstacles vanish.” I recently witnessed the rewards of patience, perseverance, and hard work on behalf of the Inspector General (IG) community with the signing of the *Emmett Till Unsolved Civil Rights Crime Act of 2007* (Public Law 110-344) by President George W. Bush. One of the Act’s provisions allows Inspectors General to make members of their staffs available to provide assistance to the National Center for Missing and Exploited Children (National Center).

Members of the President’s Council on Integrity and Efficiency (PCIE) and the Executive Council on Integrity and Efficiency (ECIE) have shown interest and support in the National Center’s work for many years. Specifically, Inspectors General Hubert Bell of the Nuclear Regulatory Commission, Martin Dickman of the Railroad Retirement Board and I have worked since 2001 to inform and generate support in the IG community regarding the contributions that IG employees may make to the National Center’s operation.

Our journey began when Ernie Allen, President and CEO of the National Center, addressed the PCIE at the invitation of several members who were associated with the National Center as volunteers. Mr. Allen spoke about the National Center’s special responsibility and commitment to making expertise, advice, and assistance available nationwide to local law enforcement agencies, which do the bulk of the investigative work in most cases involving missing and exploited children.

Since the National Center often does not have sufficient resources to maintain prolonged investigative efforts on unresolved cases, the availability of skilled investigative personnel from the Inspector General community will help it address “cold cases.” In the National Center’s experience, many such cases can be resolved through the application of professional investigative techniques because witnesses, who may have initially been reluctant to provide information, often become willing to cooperate with authorities after the passage of time and because additional physical or forensic evidence may surface as a result of scientific advancement.

The Act offers opportunities for IG special agents to use their professional skills in a uniquely human and poignant context. Most importantly, the families of missing and exploited children may receive a measure of resolution of the grievous tragedies that have darkened their lives.



THE INSPECTOR GENERAL'S MESSAGE

I believe that this Act represents a positive opportunity for the PCIE and ECIE special agents to assist the National Center. As envisioned by The Act, participation with the National Center will carry minimal resource implications for any Office of Inspector General, but can achieve significant impact in a critically underserved aspect of the National Center's work. With approximately 3,500 well-trained special agents employed by the PCIE and ECIE OIGs, the IG community has the potential to make a substantial contribution toward resolving cold cases involving missing and exploited children.

Under the terms of the Act, there will be no additional cost to the government, and the participation of any IG staff in assisting the National Center may not interfere with their ongoing official duties.

I am working with Inspectors General Hubert Bell and Martin Dickman to coordinate with the National Center and the PCIE and ECIE to begin the implementation process for this important joint effort.

Finally, I would like to take this opportunity to thank and pay a most sincere tribute to James O. Pasco, Executive Director, and Timothy M. Richardson, Senior Legislative Liaison, Grand Lodge, Fraternal Order of Police. In pursuit of this "Good Government" proposal, they permitted the auspices of the National Fraternal Order of Police to seek legislation that will uniquely help the National Center and promote once again, another example of law enforcement's charitable outreach. The IG community is forever grateful for their assistance in this matter.

A handwritten signature in black ink, reading "Patrick E. McFarland".

Patrick E. McFarland
Inspector General



MISSION STATEMENT

**OUR MISSION IS TO PROVIDE INDEPENDENT
AND OBJECTIVE OVERSIGHT
OF OPM SERVICES
AND PROGRAMS.**

WE ACCOMPLISH OUR MISSION BY:

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

GUIDING PRINCIPLES

WE ARE COMMITTED TO:

- Promoting improvements in the agency'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 the agency.
- Ensure that the agency is following best business practices by operating in an effective and efficient manner.
- Determine whether the agency 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 agency programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the agency's operations and programs administered by OPM.



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FIELD OFFICES

Office of the Inspector General





AUDIT ACTIVITIES

Health and Life Insurance Carrier Audits

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

The Office of the Inspector General (OIG) insurance audit universe contains approximately 270 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or plan mergers and acquisitions. The combined premium payments for the health and life insurance programs are approximately \$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 40 final reports on organizations participating in the FEHBP, of which 29 contain recommendations for monetary adjustments in the amount of \$44 million due the FEHBP.

COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 170 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 rates a plan offers to the FEHBP 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 SSSGs. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

Community-rated audits focus on ensuring that:

- The plans select 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 22; while a plan's basic benefit package may provide coverage only through age 19. Therefore, the FEHBP rates may be increased because of the additional costs the plan incurs by extending coverage to age 22.

During this reporting period, we issued 30 audit reports on community-rated plans. These reports contain recommendations that require the plans to return over \$24 million to the FEHBP.

Kaiser Foundation Health Plan, Inc. Pasadena, California

Northern California Region

Report No. 1C-59-00-07-018

Southern California Region

Report No. 1C-62-00-07-019

MAY 28, 2008

Kaiser Foundation Health Plan, Inc., provides comprehensive medical services to its members throughout Northern and Southern California. This audit of the plan covered contract years 2004 through 2006. During this period, the FEHBP paid the plan approximately \$2.7 billion in premiums.

We identified \$1,716,866 in inappropriate health benefit charges to the FEHBP for the Northern California region, including:

- \$837,010 in 2004;
- \$542,911 in 2005; and,
- \$336,945 in 2006.

**\$3.9 MILLION
RETURNED TO
THE FEHBP**

For the Southern California region, we identified \$1,624,268 in inappropriate health benefit charges to the FEHBP, including:

- \$885,596 in 2004;
- \$189,608 in 2005; and,
- \$549,064 in 2006.

In addition, we determined the FEHBP is due \$272,087 and \$250,157 for the Northern California



and Southern California regions, respectively, for investment income lost as a result of the overcharges.

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

These overcharges occurred because Kaiser Foundation Health Plan, Inc., inappropriately applied the standard extension of coverage loading. These overcharges were already accounted for in the claims, resulting in a double billing to the FEHBP.

The extension of coverage benefit allows Federal employees to maintain their health insurance coverage for one month after ending Federal employment.

The plan agreed with our finding and returned \$3,863,378 to the FEHBP.

- did not correctly identify an appropriate SSSG in 2005 and 2006, and failed to give the FEHBP the correct premium discount based on that SSSG;
- understated the FEHBP’s catastrophic high dollar claim credit in 2005 (catastrophic claims are usually removed because they are “outside the norm” and are not considered reflective of the actual cost to provide benefits to a group);
- understated the FEHBP’s prescription drug manufacturer’s rebate credit in 2005;
- overstated the FEHBP’s prescription drug trend in 2005 (FEHBP HMOs are required to project prescription drug costs for their plan using historical data); and,
- incorrectly applied certain prescription drug charges to the FEHBP rates in 2005.

The plan does not agree with our findings, and the report is currently in the audit resolution process.

**UPMC Health Plan
Pittsburgh, Pennsylvania
Report No. 1C-8W-00-07-028
JULY 25, 2008**

University of Pittsburgh Medical Center (UPMC) Health Plan provides comprehensive medical services to FEHBP members throughout Western Pennsylvania. This audit of the plan covered contract years 2005 and 2006. During this period, the FEHBP paid the plan approximately \$154 million in premiums.

The audit identified \$4,796,593 in inappropriate health benefit charges to the FEHBP, consisting of \$2,993,163

**AUDITORS
QUESTION CHARGES OF
\$5.4 MILLION**

in 2005 and \$1,803,430 in 2006. In addition, we determined the FEHBP is due \$617,018 for investment income lost

as a result of the overcharges. The overcharges occurred because the plan:

EXPERIENCE-RATED PLANS

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

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

- appropriateness of FEHBP contract charges and the recovery of applicable credits, including refunds;
- effectiveness of carriers’ claims processing, financial and cost accounting systems; and,
- adequacy of carriers’ internal controls to ensure proper contract charges and benefit payments.



BlueCross BlueShield Service Benefit Plan

The BlueCross BlueShield 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 59 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued seven BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors identified \$16.3 million in questionable contract costs charged to the FEHBP, including lost investment income on these questioned costs. The BCBS Association and/or plans agreed with \$14.6 million of the questioned costs.

Global Coordination of Benefits for BlueCross and BlueShield Plans Washington, D.C.

Report No. 1A-99-00-08-009
AUGUST 11, 2008

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.

Our auditors performed a computer search on the BCBS claims database, using our data warehouse function, to identify claims for services that were paid in 2005 and potentially not coordinated with Medicare. We determined that 54 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 73 percent of the 7,248 claim lines questioned, there was no information in the BCBS Association's national claims system to identify Medicare as the primary payer.

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 inappropriate costs continued to be charged to the FEHBP.

AUDITORS QUESTION OVER \$3.3 MILLION FOR COORDINATION OF BENEFITS ERRORS

We determined that the FEHBP was overcharged \$3,366,080 for these COB errors. The BCBS Association and/or plans agreed with \$2,734,920 of the questioned claim overcharges.

Health Care Service Corporation Chicago, Illinois and Richardson, Texas

Report No. 1A-99-00-07-043
SEPTEMBER 5, 2008

Health Care Service Corporation (HCSC) includes the Illinois, New Mexico, Oklahoma, and Texas BlueCross and BlueShield plans. Our audit of the FEHBP operations at HCSC covered claims from 2004 through 2006, as well as miscellaneous health benefit payments and credits, administrative expenses,



and cash management activities from 2002 through 2006 for the Illinois and Texas plans only. From 2002 to 2006, HCSC paid approximately \$5.6 billion in FEHBP health benefit charges and \$341 million in administrative expenses for the Illinois and Texas plans.

Our auditors questioned \$6,430,166 (\$6,520,660 in health benefit overcharges less \$90,494 in administrative expense

**BCBS ASSOCIATION
AGREES WITH \$6.4 MILLION
IN QUESTIONED CHARGES**

undercharges). The findings included the following:

- \$3,293,780 in overpayments and \$33,037 in underpayments due to claim pricing errors;
- \$3,015,707 in overpayments and \$152,091 in underpayments because claims were not paid in accordance with the Omnibus Budget Reconciliation Act of 1990 pricing requirements, which limit benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$789,028 for plan employee pension cost undercharges from 2002 through 2004;
- \$672,200 for pension cost overcharges in 2005 and 2006;
- \$227,670 for lost investment income on health benefit refunds and recoveries that were either not returned to the FEHBP or not returned in a timely manner;
- \$22,344 for executive compensation overcharges; and,
- \$3,990 in administrative expenses that were unallowable charges to the FEHBP.

The BCBS Association agreed with all of these questioned charges. Lost investment income on the questioned charges totaled \$91,861.

Global Duplicate Claim Payments for BlueCross and BlueShield Plans

Report No. 1A-99-00-08-008

SEPTEMBER 11, 2008

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to duplicate claim payments.

Using our data warehouse, we performed a computer search for potential duplicate payments on claims that were paid during the period January 1, 2004 through December 31, 2005. Our auditors identified 3,701 duplicate claim payments, and found that 60 of the 63 plan sites had made duplicate payments. We noted that the BCBS national claims system had failed to identify approximately 50 percent of these claims as potential duplicates.

**FEHBP OVERCHARGED
\$2.6 MILLION
FOR DUPLICATE
CLAIM PAYMENTS**

We determined that the FEHBP was overcharged \$2,658,529 for these duplicate claim payments. The BCBS Association agreed with all of the questioned overcharges.

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: American Postal Workers Union; Association of Retirees of the Panama Canal Area; Government Employees Hospital Association; National Association of Letter Carriers; National Postal Mail Handlers Union, and Special Agents Mutual Benefit Association.

We issued no audit reports on employee organization plans during this reporting period.



Information Systems Audits

OPM relies on computer technologies and information systems to administer programs that distribute health and retirement benefits to millions of current and former Federal employees. OPM systems also assist in the management of background investigations for Federal employees, contractors, and applicants. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these Federal systems could compromise the privacy of the individuals whose information they maintain, as well as the efficiency and effectiveness of the programs that they support. With recent high-profile security incidents involving personal information, privacy has emerged as a major management challenge for most Federal agencies and OPM is no exception.

Our office examines 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).

Audit of Information Systems General and Application Controls at BlueCross BlueShield of Massachusetts

Boston, Massachusetts

Report No. 1A-10-11-08-001

MAY 28, 2008

This audit covered the system that processes FEHBP claims for BlueCross BlueShield of Massachusetts (BCBSMA), as well as the business structure and control environment in which it operates. Our audit focused on the claims processing applications used to adjudicate FEHBP claims for BCBSMA, as well as the various processes and IT systems used to support these applications. In addition, we evaluated BCBSMA's compliance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and costs associated with implementing the HIPAA requirements. We documented controls in place and opportunities for improvement in each of the following areas:

■ *Entity-wide Security*

BCBSMA has established a comprehensive series of IT policies and procedures to create an awareness of IT security in its offices. BCBSMA has also implemented an adequate risk assessment methodology, incident response capabilities, and IT security related human resources controls.



■ *Access Controls*

We found that BCBSMA 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 noted that the physical security of checks received in the mail room, as well as the logical authentication requirements of Windows workstations, could be improved.

■ *Application Development and Change Control*

BCBSMA has established policies and procedures to ensure that modifications to application software occur in a controlled environment. Such controls include: the use of an automated tool to manage software modifications; various levels and types of system testing in accordance with industry standards; and segregation of duties along organizational lines.

■ *Service Continuity*

We reviewed BCBSMA's business continuity and disaster recovery plans and concluded that they contained many of the key elements suggested by relevant guidance and publications. We also determined that these documents are reviewed, updated, and tested periodically.

■ *Application Controls*

BCBSMA has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we recommended that BCBSMA and the BCBS Association implement additional technical controls to improve the accuracy of the claims adjudication process.

■ *Health Insurance Portability and Accountability Act (HIPAA)*

We did not discover any incidents of noncompliance with the HIPAA requirements.

Federal Information Security Management Act Audit – FY 2008

Washington, D.C.

Report No. 4A-CI-00-08-022

SEPTEMBER 23, 2008

The Federal Information Security Management Act of 2002 requires that the information resources and assets supporting Federal operations are appropriately protected. FISMA emphasizes that agencies implement security planning for their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's inspector general. Consequently, we audited OPM's general FISMA compliance efforts for specific areas defined in the Office of Management and Budget's (OMB) FY 2008 Reporting Instructions for FISMA.

We found that OPM has made progress in strengthening its IT security program since the inception of the FISMA auditing and reporting requirements in 2002. However, we continue to have some significant concerns with aspects of the program.

Last year, we reported a material weakness in the controls of the development and maintenance of OPM's IT security policies. Major elements of the policies have not been updated in five years. We found significant deficiencies in the control structure of OPM's management of major system certification and accreditation, as well as in the plan of action and milestones process.

OPM is committed to developing and maintaining strong IT security controls. However, it is clear that there are opportunities for improvement in the overall leadership and management of the IT security program.

The agency has operated without a permanent IT security officer for over six months. This position requires a long-term commitment to managing an ever-changing



IT environment. The security officer must be capable of working with agency program office representatives who have diverse IT security experiences. The auditors recommended that OPM hire a permanent IT security officer with adequate staff to effectively manage the agency's IT security program.

Additionally, the auditors noted that OPM has:

- completed privacy impact assessments (PIA) for each of the required 28 systems;
- made progress in implementing requirements of Office of Management and Budget's (OMB) Memorandum 07-16, "Safeguarding Against and Responding to the Breach of Personally Identifiable Information;"

- not implemented the Federal Desktop Core Configuration requirements; and,
- provided annual IT security and privacy awareness training.

We also audited four major OPM computer systems in FY 2008. The areas that we reviewed included self-assessment, contingency planning and testing, certification and accreditation (including risk assessment and security controls testing), and the plan of action and milestones (POA&M) process. Our audit revealed substantial compliance with FISMA requirements. However, we did identify weaknesses in certain areas.

The FY 2008 FISMA review resulted in a total of six audit reports.



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

Audit of OPM's Implementation of the Office of Management and Budget Circular A-123, Appendix A Washington, D.C.

Report No. 4A-CF-00-07-062

JUNE 23, 2008

We conducted a performance audit of OPM's implementation of OMB Circular A-123, *Management's Responsibility for Internal Control*, which defines management's responsibility for internal control in Federal departments and agencies. In December 2004, OMB revised Circular A-123 and introduced Appendix A, which prescribes a strengthened process to assess the effectiveness of the internal control over financial reporting (ICFR). OMB Circular A-123, Appendix A, was developed to address an ongoing concern in the Executive Branch of the Government that the financial reports of Federal agencies were not reliable and did not reflect accepted accounting standards.

OPM developed an evaluation and test plan (Test Plan) as required by the circular. The agency also established the Senior Assessment Board to provide oversight and guidance during the ICFR assessment process, from the planning stages of the review to the resolution of corrective actions. OPM's Policy and Internal Control Group (PICG):

- conducted the ICFR assessment;
- facilitated OPM's development of assessable units (AUs);
- conducted a risk assessment to determine the level of testing necessary for the ICFR assessment;
- identified and tested controls; and,
- summarized and reported the results of the ICFR assessment and other information to formulate the OPM Director's assurance statement on ICFR.

We found that OPM's Test Plan did not include specific guidance on how to document the ICFR assessment. The Test Plan did not totally adhere to OMB Circular A-123 documentation requirements for the ICFR assessment, as it lacked the:

- assessment methodology;
- evaluation of control testing performed; and,
- performance of test models identified on the ICFR form.

In addition, we found that the PICG did not retest reportable conditions June 30 and September 30 as required by the Test Plan.

OPM agreed with our finding and recommendations. Corrective actions have been implemented.



Agreement between OPM and the National Archives and Records Administration for the Storage and Servicing of Records Washington, D.C.

**Report No. 4A-CA-00-07-054
AUGUST 26, 2008**

At the request of the former OPM Director, we conducted a performance audit of the agreement between OPM and National Archives and Records Administration (NARA) for the storage and servicing of records. Our audit focused on the Interagency Agreement between OPM and NARA for FY 2007 and the Memorandum of Understanding (MOU) between the two agencies.

In 1988, OPM signed an MOU with NARA relating to the ownership, retention and maintenance of separated civilian employees' records, including:

- Official Personnel Folders (OPFs);
- Merged Records Personnel Folders (MRPFs); and,
- Employee Medical Folders (EMFs).

The files in all three record systems are stored at NARA's National Personnel Records Center (NPRC).

The OPF is the official repository of records and reports of personnel actions effected during an employee's government service. By executive order, OPFs are the property of OPM. MRPFs consist of records and documents maintained by Federal personnel systems. Separated employees' MRPFs, also stored at NPRC, are the property of the agency that created the records and are handled according to the MOU. EMFs include all occupationally related medical records created during an employee's Federal civilian service. These records are also the property of OPM.

NPRC is responsible for the retention, maintenance, and safeguarding of these records until they are requested by a designated Federal agency official or until the authorized retention period of the file expires, whichever comes first. Under the MOU, NARA bills OPM for the costs of its services.

We identified five areas requiring improvement:

- OPM and NARA have not updated the MOU since 1988.
- OPM does not have written policies and procedures outlining the steps involved in negotiating, reviewing, and approving the Interagency Agreement with NARA.
- OPM's Center for Information Services (CIS) does not have a sufficient process for validating all amounts shown on the monthly invoice from NARA prior to authorizing payment by the Office of the Chief Financial Officer. They also do not have a process for validating transactions between NARA and other Federal agencies.
- OPM's CIS has not authorized any action on 15 records eligible for disposal in FY 2007.
- NARA's St. Louis, Dayton, and Washington records centers incorrectly billed OPM for services rendered in April, June, and July 2007. The dollar values of the errors were immaterial; however, the errors highlighted an internal control weakness that should be corrected.

**AUDITORS IDENTIFIED
CRITICAL AREAS
FOR IMPROVEMENT**

OPM and NARA agree with our findings and are currently working on implementing corrective actions.



COMBINED FEDERAL CAMPAIGN

Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM is responsible, 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 OIG 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.

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 a member of a federation for the purposes of the CFC.

During this reporting period, we issued one audit report of a local CFC in Rancocas, New Jersey. The report identified six violations of regulations and guidelines governing local CFC operations. Specifically, the report identified the following:

- **One-Time Disbursements**

The PCFO did not obtain approval from the LFCC to make one-time disbursements to organizations receiving a small donation amount. In addition, the disbursements were not made by the date required by the Federal regulations.



■ **Campaign Expense Reimbursement**

The PCFO was reimbursed for campaign expenses based on estimates rather than actual costs.

■ **Campaign Expenses Not Properly Supported**

The PCFO did not have sufficient supporting documentation for some expenses charged to the 2005 campaign.

■ **Inappropriate Allocation Method**

The PCFO did not use an appropriate allocation method to distribute salary and office expenses to the 2005 campaign.

■ **PCFO Application Not in Compliance**

The PCFO application approved by the LFCC was not in compliance with all mandatory statements and references in the Federal regulations.

■ **Agreed-Upon Procedures Not in Compliance**

The IPA did not comply with all aspects of the Agreed-Upon Procedures in the CFC Audit Guide. Specifically, the IPA did not complete two audit steps; drew improper conclusions for two steps; and, did not maintain appropriate supporting documentation for two other steps.

We provide our audit findings and recommendations for corrective action to OPM management, which subsequently notifies the CFC organizations and monitors the corrective actions. If the CFC organization does not comply with the recommendations, the OPM Director can deny the organization's future participation in the CFC.

National Charitable Federation Audits

We also audit national charitable federations that participate in the CFC. National federations provide services to other charities with similar missions. They are similar to local federations, since they provide common fundraising, administrative, and management services to their members. Our audits of the national federations focus on the eligibility of member charities, distribution of funds, and allocation of expenses.

During this reporting period, we did not issue any reports on national charitable federations that participated in the CFC.

FEDERAL LONG TERM CARE INSURANCE PROGRAM

The Federal Long Term Care Insurance Program (FLTCIP) was established by the Long Term Care Security Act of 2000 for Federal employees and annuitants, current and retired members of the uniformed services, and qualified relatives.

In December 2001, OPM awarded a contract to Long Term Care Partners (LTCP) to provide and administer long term care insurance benefits. LTCP is a joint venture, equally owned by John Hancock Life Insurance Company and Metropolitan Life Insurance Company (referred to as the Carriers). LTCP is responsible for all administrative functions of the FLTCIP.

**Long Term Care Partners, LLC
Portsmouth, New Hampshire
Report No. 1G-LT-00-07-055
AUGUST 4, 2008**

This audit covered the FLTCIP's claim benefit payments, administrative expenses, and cash management activity for FY 2006, and disbursements for liabilities incurred in prior years. During this period, premiums and net investment income totaled \$288 million, and disbursements totaled \$78 million. LTCP paid:

**AUDITORS
QUESTION OVER
\$1.5 MILLION**

- \$8,176,127 in long term care claim payments;
- \$18,948,189 in administrative expenses; and,
- \$50,936,119 to the carriers for expenses incurred during FY 2006 that related to current and prior year liabilities.



In addition, our auditors found that LTCP had understated their earned investment income to the plan by over \$30 million. Though this is not a finding that results in a reimbursement to the Government, it reflects an inaccurate reporting problem that needs to be addressed.

Our auditors identified \$1,534,293 in program overcharges. Specifically, we found:

- \$864,963 in overcharges for deferred acquisition cost taxes;
- \$194,716 in profit overcharges;
- \$193,653 in lost investment income because John Hancock delayed the transfer of Program funds (premiums) from its general account to its FLTCIP Separate Account;
- \$149,933 in lost investment income because John Hancock did not invest FLTCIP funds in its Separate Account in a timely manner;
- \$96,028 in unallowable administrative expenses related to employee activities for fiscal years 2002 through 2007; and,
- \$35,000 charged to the FLTCIP instead of the Federal Employees Dental and Vision Insurance Program.

LTCP agreed with \$1,340,640 in questioned charges.

PHARMACY BENEFIT MANAGER AUDITS

The BCBS Association, on behalf of participating BCBS plans, entered into a contract with OPM to provide a health benefit plan as authorized by the Federal Employees Health Benefit Act. AdvancePCS (APCS) provided retail pharmacy benefits, processed pharmacy claims, and paid retail pharmacy providers on behalf of the BCBS plans participating in the FEHBP during contract years 2000 through 2005.

AdvancePCS

Scottsdale, Arizona

Report No. 1H-01-00-04-102

SEPTEMBER 29, 2008

Our audit of operations for 2000 through 2002 determined whether APCS:

- complied with contract provisions relative to benefit payments;
- properly adjudicated FEHBP claims;
- properly calculated the FEHBP portion of drug manufacturer rebates; and,
- promptly returned pharmacy drug rebates to the FEHBP.

We reviewed claim samples of approximately \$1.4 million in retail pharmacy payments from 2000 through 2002, for duplicate payments and/or improper adjudication. Also, we reviewed approximately \$206 million in manufacturer drug rebates for 2000 through 2002, to determine whether rebates were properly calculated and returned to the FEHBP.

**AUDITORS IDENTIFY
POTENTIAL LOSS OF
\$4.5 MILLION
TO THE FEHBP**

The audit revealed that APCS paid claims for patients that were not enrolled in the BCBS Service Benefit Plan. Consequently, the FEHBP was potentially overcharged \$4.5 million for claim errors identified due to retroactive enrollment changes. Retroactive enrollment changes occur when subscriber changes are not known when the claims are filed for payment.

The BCBS Association contested our finding, and the audit is currently in the audit resolution process.



AdvancePCS

Scottsdale, Arizona

Report No. 1H-01-00-06-040

SEPTEMBER 29, 2008

Our audit of APCS operations for 2003 through 2005 was conducted to determine if:

- processing and administrative fees charged to the FEHBP were in compliance with the contract;
- pharmaceutical manufacturer rebates were correctly calculated and returned to the FEHBP; and,
- administrative fees charged by APCS to pharmaceutical manufacturers were in accordance with applicable contracts.

We reviewed the BCBS FEHBP annual accounting statements covering retail pharmacy drug costs for contract years 2003 through 2005. BCBS paid APCS approximately \$7 billion for these costs. Specifically, we reviewed approximately \$333 million of the \$450 million in pharmaceutical manufacturer reimbursements, such as drug rebates and

administrative fees, from 2003 through 2005 for proper calculation and/or allowability. We also reviewed a sample of 250 retail pharmacy claims totaling \$10,297 for proper adjudication. Finally, we reviewed all APCS invoices to the Association for contractual compliance.

**AUDITORS QUESTION
OVER \$2 MILLION
IN OVERCHARGES**

The audit identified \$2,160,781 in program overcharges, including \$305,068 for lost investment income. Specifically, we found:

- \$1,518,695 was overcharged in 2004 and 2005 for monthly customer service fees (specifically, the monthly customer service fees charged to the FEHBP were in excess of the negotiated contract rate); and,
- \$337,018 was overcharged in 2003 through 2005 for unallowable program expenses.

The Association disagreed with the amounts questioned, and the audit is currently in the audit resolution process.



ENFORCEMENT

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds of approximately \$750 billion for all Federal civilian employees and annuitants participating in Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), FEHBP, and FEGLI. These programs cover over eight million current and retired Federal civilian employees, including eligible family members, and disburse about \$91 billion annually. While we investigate OPM employee misconduct and other wrongdoing, the majority of our OIG investigative efforts are spent examining potential fraud against these trust funds.

During the reporting period, our office opened 76 criminal investigations and closed 114, with 255 still in progress. Our investigations led to 25 arrests, 24 indictments and/or informations, 22 convictions and \$17,355,792 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 30.

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.

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



The OIG 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 debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions.

HEALTH CARE FRAUD CASES

Pharmaceutical Company Agrees to \$425 Million Settlement

In September 2008, Cephalon Inc., a pharmaceutical company, agreed to pay the Federal government \$425 million to resolve civil suits that claimed the manufacturer marketed three drugs for uses not approved by the Food and Drug Administration (FDA).

The Government charged that the company marketed the drugs for unapproved uses, often called “off-label” marketing, in violation of the Food, Drug and Cosmetic Act. As a result of the company’s off-label marketing campaign, health care providers prescribed certain medication produced by Cephalon for unapproved uses. These are considered false claims for payment when submitted to Federal health care insurance programs, such as Medicaid and the FEHBP.

Cephalon undertook its off-label promotional practices using a variety of techniques, such as training its sales force to disregard restrictions of the FDA-approved label, and to promote the drugs for off-label uses. They employed sales representatives and retained medical professionals to speak to doctors about uses of the three drugs. The company funded millions of dollars in continuing medical information programs to promote off-label uses of its drugs.

The FEHBP received \$13,967,347 in the settlement. Additionally, the company pled guilty to a misdemeanor charge for off-label promotion.

This was a joint investigation with the U.S. Attorney’s Office in the Eastern District of Pennsylvania, DOJ’s Civil Division, FDA, Department of Health and Human Services (HHS) OIG, U.S. Postal Service OIG, Association of Medicaid Fraud Control Units and the Connecticut Attorney General’s Office.

Anesthesiologist and FEHBP Enrollees Sentenced after Record Forfeiture

In our semiannual report ending March 31, 2008, we reported on a Maryland physician who pled guilty to making a false statement regarding health care claims. He admitted to filing claims for medical injections not administered. In July 2008, he was sentenced to 37 months incarceration. The physician previously forfeited \$5 million, of which OPM received \$655,270. According to the Assistant United States Attorney, this forfeiture was a record in Washington, D.C. for a health care fraud case.

Also, this investigation led to the convictions of three FEHBP enrollees and the physician’s office manager. One enrollee was sentenced to 57 months incarceration for trafficking OxyContin, which was obtained through his FEHBP health benefits. In addition, two other enrollees, a husband and wife, were sentenced to 12 months of probation for illegally obtaining and falsifying narcotic prescriptions. The physician’s office manager will be sentenced in the near future.

Physician Sentenced for Health Care Fraud and Tax Evasion

In July 2008, a Washington, D. C. area primary care physician was sentenced to 65 months in prison, three years of supervised release, and ordered to pay \$802,253 in restitution.

He submitted false claims to the FEHBP and other health care programs for hospital services that he supposedly rendered to his patients. Among other charges, the physician in November 2002, submitted false



claims for treating patients admitted to a hospital in Washington, D.C., although he was in South Carolina. In addition, from 1997 through 2005, the physician evaded payment of more than \$400,000 in taxes.

We originally reported this case in the semiannual report for the period ending March 31, 2008.

This was a joint investigation between the IRS, Federal Bureau of Investigations (FBI), HHS/OIG and our office.

Louisiana Clinic Operator Commits Insurance Fraud

In July 2008, a Baton Rouge clinic operator, who represented himself as a licensed physician, was found guilty by a Louisiana state jury of committing insurance fraud. The operator's clinic provided braces for scoliosis patients. Even though scoliosis is a condition that can only be managed, not cured, the operator ensured patients that his braces could partially improve or completely cure their condition.

The operator demanded payments from the patients prior to rendering services and he instructed his patients to submit claims to their health insurance carrier for reimbursement. He, at various times, hired chiropractors to work in his clinic. However, because of his questionable practices, they often left shortly after being employed. He would then continue to bill for chiropractor services using their identities even though he personally administered the treatments.

BlueCross BlueShield (BCBS) of Louisiana referred this case to our office after an extensive internal investigation, which led to a joint investigation between the Louisiana Attorney General's Office and our office.

Sentencing is scheduled for November 2008.

Texas Psychologist Charged with Illegal Billing

In March 2008, a Texas psychologist was indicted on 15 counts of health care fraud by a Federal grand jury. The psychologist worked for a Corpus Christi, Texas hospital providing counseling services and diagnostic testing for children.

Investigators determined that the psychologist hired graduate students to provide unsupervised counseling services to children, but billed both the FEHBP and Medicaid program as if he, the licensed psychologist, performed the services from January 2001 until February 2008. The agents found that he billed for the services under his name to increase the reimbursement from the FEHBP and Medicaid.

In June 2008, the psychologist was convicted of health care fraud. Sentencing is scheduled for January 2009. This was a joint investigation with the FBI, the Texas Medicaid Control Fraud Unit and our office.

Spouse of Postal Employee Charged with "Doctor Shopping"

The spouse of a postal employee confessed to insurance fraud and was indicted by a Texas grand jury. At the time of arrest, she was already serving 60 months probation for drug violations. She allegedly engaged in "doctor shopping," a practice of secretly consulting with multiple physicians to obtain duplicate prescriptions, from January 2003 through January 2008, costing the FEHBP nearly \$500,000. It was not unusual for her to daily visit several doctors, emergency rooms, and diagnostic clinics. She estimated that she received as many as three CAT scans per day to diagnose unspecific pain. During each visit, she would request prescriptions for Hydrocodone, which she would mix with acetaminophen.



The 40 year-old woman admitted that she has been addicted to drugs since the age of 12. We determined that she was prescribed over 14,000 tablets, was treated by 306 medical providers, and traveled to over 43 pharmacies to have her prescriptions filled during the five year investigative period. Her husband was also questioned and admitted to drug abuse.

The BCBS Association referred the case to our office. This is a joint investigation with the FBI.

Border Patrol Agent Charged With Distributing FEHBP Acquired Drugs

In November 2007, two females were arrested crossing the New Mexico/Mexico border with drugs in their possession, including Methamphetamine. During interviews with the U.S. Customs and Border Protection (CBP) agency, the two women identified a Border Patrol Agent with whom they often socialized. Additionally, they saw this agent associating with high ranking Mexican drug cartel members.

The CBP Office of Internal Affairs (OIA) opened an investigation and found that the individual had submitted to an FEHBP carrier several claims for prescription drugs. After CBP-OIA notified our office of the investigation, we determined that the FEHBP carrier also had an open investigation.

The joint investigation determined that the agent had participated in “doctor shopping” and used and distributed the drugs. During our investigative period, the agent was assigned to New Mexico and Texas. The carrier’s prescription management contractor determined that the agent had obtained prescription drugs from the FEHBP for over 16 months.

In addition to fraudulently obtaining the prescription drugs in the U.S., the agent purchased additional prescription drugs in Mexico. The FEHBP carrier continues to review files to determine the total number of prescriptions obtained by the agent.

In September 2008, he was arrested in Maverick County, Texas on a New Mexico state warrant. He was charged in Chavez County, New Mexico with controlled substance offenses. While awaiting trial in New Mexico, the agent was released on a \$250,000 bond.

This is a joint investigation with the CBP-OIA.

Maine Chiropractor Pleads Guilty to Health Care Fraud and Tax Evasion

In November 2004, the U. S. Attorney’s Office in Portland, Maine, notified our office of double billing by a chiropractor in Damariscotta, Maine. The chiropractor collected payment from the patient and then billed the patient’s FEHBP insurance carrier for the same service. The doctor was also suspected of charging for services not rendered.

Chiropractic services require direct contact with the patient and are generally billed in 15 minute increments. Analysis of insurance claims submitted by the chiropractor revealed that he billed for more treatments than it was possible to provide. For example, on some occasions, he billed for 19 hours of patient therapy. On at least one day, he billed for as much as 39 hours of direct patient contact. The investigators found that losses incurred by health insurance companies exceeded \$100,000.

The investigation also revealed that the chiropractor was evading income taxes. From 2001 to 2003, the chiropractor submitted false tax returns understating his true income. To conceal his income, he deposited payments from his patients into a joint account held with his sister, which was never reported to the Internal Revenue Service (IRS). An IRS audit revealed that the chiropractor evaded taxes of \$249,637.

In June 2008, the chiropractor waived indictment, and pled guilty to health care fraud and tax evasion. The chiropractor was released pending sentencing.

This case was investigated by the FBI, the IRS, the Department of Labor OIG and our office.



New York Ophthalmologist Convicted of Performing Unnecessary Surgeries

A New York ophthalmologist was indicted in January 2005, for performing unnecessary eye treatments, including cataract surgeries and punctal occlusion procedures (plugs) for dry-eye syndrome. He also falsified patient records, by altering eye pressure readings to justify unnecessary cataract surgeries, placing patients at risk.

From 1999 to 2004, he recruited patients:

- during meetings held in religious community centers on Staten Island;
- through pamphlet distributions throughout the community; and,
- by word of mouth advertising.

His practice targeted the elderly population.

In November 2007, shortly before his scheduled trial, the ophthalmologist pled guilty to health care fraud. He was sentenced in June 2008, to five years in prison and three years probation. He was also ordered to pay a criminal fine of \$100,000 and criminal restitution of \$70,000. Additionally, his office manager was convicted of making false statements related to health care claims. She was sentenced in July 2008 to two years probation.

A parallel civil case is pending for recovery of damages incurred by Federal health insurance programs, including the FEHBP. The FEHBP recovery is yet to be determined. This case was investigated by the FBI, HHS-OIG, U.S. Postal Inspection Service and our office.

Pharmaceutical Company Agrees to Repay Government \$499 Million

In October 2007, Bristol Myers Squibb, a pharmaceutical company, agreed to settle civil charges that it engaged in illegal kickback schemes. Their business practices included inducing retail pharmacies to purchase their products in return for paid remunerations (i.e., stocking allowances, free goods, and refunds in advance of sales), and physicians to prescribe the company's medications.

In addition, the pharmaceutical company artificially inflated the average wholesale price of its drugs and illegally marketed the drugs for off-label uses in violation of the Food, Drug and Cosmetic Act. This resulted in thousands of false claims filed for reimbursement by government health care programs including: Medicare, TRICARE, Medicaid, Veterans Administration Health Care System, and the FEHBP.

The company agreed to reimburse the government \$499 million plus 4.5 percent interest. The FEHBP has been reimbursed \$828,380 for the pharmaceutical company's off-label marketing.

RETIREMENT FRAUD

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

Our Office of Investigations uses a variety of approaches to identify potential cases for investigation. One of our proactive initiatives is to review data to identify annuitant records with specific characteristics and anomalies that have shown, in the past, to be good indicators of retirement fraud. We also use automated data systems available to law enforcement agencies to obtain information on annuitants that may alert us of instances where payments should no longer be made. We confirm the accuracy of the information through



follow-up inquiries. Routinely, OPM's Center for Retirement and Insurance Services refers to our office potential fraud cases identified through computer death matches with the Social Security Administration. Other referrals come from Federal, state, and local agencies, as well as private citizens.

Son of a Former Massachusetts Postmaster Pled Guilty To Theft

The son of a former Federal survivor annuitant failed to notify OPM of his mother's death and knowingly stole and converted to his own use her Federal annuity payments to which he was not entitled. The survivor annuitant was the spouse of a former postmaster. After her death in 1997, the son fraudulently received his mother's annuitant payments for over 10 years by receiving Government checks, and later, electronic funds transfer deposits to a joint bank account listed under his and the mother's names. He stated that he used the funds to meet daily expenses.

In June 2008, the son pled guilty to theft of \$139,758 in Federal funds, and forfeited the Cape Cod residence he inherited from his mother. Sentencing is scheduled for November 2008.

The agency's Center for Retirement and Insurance Services referred this case to our office and the United States Secret Service assisted with the investigation.

Deceased Mother's Retirement Funds Used for Gambling

Although a Maryland survivor annuitant died in October 1997, her daughter failed to notify OPM of the death, resulting in an overpayment of \$112,685 in retirement annuitant funds. The payments were electronically transferred to the joint account of the annuitant and her daughter. During one interview with our investigator, the daughter admitted that she used the funds to make her mortgage payments and to gamble at several casinos in Las Vegas and Atlantic City.

To make it appear that her mother was alive, the daughter kept a home telephone number in her mother's name and also forged her mother's name on two OPM address verification letters.

In September 2008, the daughter pled guilty to one count of theft of Government funds. She was ordered to pay full restitution. Her sentencing is scheduled for December 2008.

The agency's Center for Retirement and Insurance Services referred this case to our office.

Family Reports Daughter of a Deceased Annuitant for Theft of Retirement Checks

A Chicago area deceased annuitant's grandson was asked by his mother to deposit his grandfather's check into his personal checking account. Although the grandson previously deposited checks for his mother, he became disturbed because she continuously over-drew his account. At that point, he advised his father, who happened to be a police officer, of the situation. The father then reported to the U.S. Secret Service that his former wife was illegally obtaining the proceeds of her father's annuity checks.

Our investigation disclosed that the daughter failed to notify the OPM of her father's death in March 1999. She received her father's civil service retirement benefits from April 1999 to July 2006. The benefits were initially electronically deposited into a joint bank account she shared with her father. Later, the daughter instructed OPM to switch the annuity payment process from electronic deposit to mailing checks to her home address.

During the investigative interview, she stated she deserved the money, since she was the one who cared for her father, and her siblings never compensated her. She further stated she used the money to maintain her lifestyle (she admitted to forging her father's signature on numerous annuity checks).



In February 2008, the daughter pled guilty to embezzlement and theft. In August 2008, she was sentenced to 12 months of home detention; 60 months probation; 200 hours of community service; and ordered to pay restitution of \$119,682.

This was a joint investigation between our office and the U.S. Secret Service.

Massachusetts Man Charged With Forging Annuity Checks

In May 2008, the Massachusetts Attorney General's Office (AGO) notified our office of a possible retirement fraud case involving the nephew of a deceased Federal annuitant. The AGO advised that in November 2007, the nephew was indicted by the state on 282 felony counts, for his alleged involvement in:

- mortgage fraud;
- insurance fraud;
- identity theft;
- credit card fraud; and,
- practicing law without a license.

An arrest warrant was issued after he failed to appear at his arraignment. On February 14, 2008, he attempted to escape prosecution by flying to Las Vegas from Rhode Island. While going through airport security, he set off security detection devices, and Transportation Security Administration officers notified the airport police. The nephew attempted to flee and was apprehended in the parking lot. Police conducted a criminal records check and found that he was wanted by Massachusetts authorities.

His car was impounded and inventoried. His aunt's 2006 OPM annual "Statement of Paid Survivor Annuity" was found among the inventoried documents in his car. The OPM/OIG then joined the investigation and established that his aunt was a deceased Federal annuitant. Our investigation determined that since her death

in November 2005, the nephew received, forged, and cashed 28 of her annuity checks totaling over \$34,000.

In August 2008, the nephew was indicted in state court and charged with an additional 28 counts of felony larceny for each of the annuity checks.

Settlement Results in a \$266,000 Repayment After Son Admits to Using Annuity for Personal Expenses

The OPM Center for Retirement and Insurance Services determined that a North Carolina Federal annuitant died in April 1984. However, OPM was never notified of her death. During the investigation, we identified the annuitant's son as the joint account holder on the deceased annuitant's account. Her son received fraudulent payments of \$265,664.

Analysis of bank records revealed the annuity payments were the only deposits into the joint account. The annuitant's son typically withdrew funds from the account by writing checks made out to "Cash." Moreover, he wrote checks to:

- pay credit card bills;
- make deposits into investment accounts;
- make major purchases such as appliances;
- pay for boat cleaning and storage; and,
- pay landscaping expenses.

The annuitant's son claimed that when he notified OPM after his mother's death, he was informed that he was the beneficiary of the annuity and that the payments would continue. However, we determined that OPM was never notified of the mother's death.

The United States Attorney's Office pursued the case civilly for violations of the False Claims Act. Subsequently, the son entered into a settlement agreement for full repayment of \$265,664.



Identity of Forger Revealed by Check Cashing Store's Photographs

In July 2008, the daughter of a deceased Federal annuitant pled guilty to theft of public money. Based on a returned OPM address verification letter with the forged signature of the deceased annuitant, OPM continued issuing benefits checks after her death in June 1990. In 2005, the Social Security Administration (SSA) OIG notified our office of the forgery of OPM annuity checks at a New York check cashing store. Subsequently, our office notified OPM, which stopped the benefits at that time.

The investigators found that the checks were negotiated at multiple check cashing stores in New York. One of those stores routinely photographed its customers during transactions and retained the photographs on microfilm. Photographs received from the store identified the daughter as the forger. The investigators determined that fraudulent payments to the daughter were \$132,137.

Sentencing is scheduled for October 2008.

This was a joint investigation with SSA/OIG, the FBI, the U.S. Secret Service, and our office.

Daughter Convicted of Theft of Annuity Payments

Through our proactive initiative, our office verifies if annuitants who are 100 years or older are still living. During a review, we determined that a retired Federal employee residing in California died in December 1986. However, until April 2005, monthly payments continued for her civil service and survivor annuities.

The deceased shared a joint bank account with her daughter, who took \$130,450 in payments issued after her mother's death. In 2002, more than 15 years after her mother died, the daughter notified OPM to change the annuitant's address on file to her residence.

The daughter confessed to our investigators that she illegally received the annuity payments. In June 2008, she pled guilty in Ohio to theft of public money. In September 2008, the daughter was sentenced to three months home confinement; five years probation; and, ordered to pay \$130,450 in restitution, plus a \$100 special assessment.

Annuitants' Daughter Incarcerated for Retirement Fraud

In our semiannual report for the period ending March 31, 2008, we reported an investigation and subsequent indictment of the daughter of two deceased former Federal retirees. Our investigators found that the father, a Federal retiree, died in May 1982 leaving his spouse, also a retired Federal employee, a survivor benefit. In February 1995, the mother died; however, the daughter failed to notify OPM. The daughter, by falsely reporting to OPM that her mother was still alive, continued to receive her mother's retirement annuity as well as her father's survivor benefit. The daughter fraudulently received \$282,891.

In May 2008, the daughter pled guilty to theft of government property and mail fraud. In July 2008, she was sentenced to 15 months incarceration; 36 months supervised release; and, \$282,891 in restitution.

This case was jointly investigated by the U.S. Postal Inspection Service and our office.



Daughter of Deceased Annuitant Sentenced to Two Years Incarceration

As also reported in our last semiannual report, OPM determined that a Federal annuitant died in Hawaii in December 1995 and his death was not reported. While investigating the case jointly with the FBI, we determined that the deceased annuitant's daughter had access to the decedent's bank accounts after his death. When confronted, the daughter confessed that she intentionally failed to notify OPM of her father's death and continued to receive his annuity payments. She also admitted forging his signature on various OPM forms.

In March 2008, the daughter pled guilty to theft of government property and aggravated identity theft. In June 2008, she was sentenced to 24 months of incarceration; one year of home detention; and, full restitution of \$208,493.

Son Sentenced to Incarceration and Garnishment of SSA Benefits

Through our proactive initiative, we determined that a Federal annuitant died in Hawaii in March 2002. However, electronic deposits of her annuity payments continued until November 2005. While working jointly with the FBI, we were able to identify the deceased annuitant's son as the suspect of annuity fraud. In May 2008, the son pled guilty to mail fraud and theft of Government property.

In August 2008, the son was sentenced to 15 months incarceration; three years supervised release; full restitution of \$134,914; and, a \$4,000 fine. The judge ordered garnishment of the son's Social Security benefits to repay the debt. The garnishment of Social Security benefits is an uncommon method of recovering funds owed to the Civil Service Retirement System.

Daughter and Grandson Conspired in the Theft of Government Funds

Through our proactive initiative, we determined that annuity payments continued until January 2005 for a deceased Texas annuitant who died in January 1995. The investigation revealed that his daughter and grandson converted the annuity payments for their personal use, which included multiple trips to out-of-state casinos. In October 2007, both were indicted and subsequently arrested on multiple conspiracy charges. In January 2008, they pled guilty to conspiracy and to conspiring in the theft of Government funds.

In May 2008, the grandson was sentenced to 5 months incarceration and 36 months probation, while the daughter was sentenced to 10 months home detention and 36 months probation. Also, they were ordered to pay restitution to OPM in the amount of \$103,572, for which they are jointly liable.

SPECIAL INVESTIGATIONS

Former OPM Employee Sentenced for Falsifying Records

In our semiannual report ending March 31, 2008, we highlighted an investigation involving a former OPM Federal Investigative Services Division (FISD) background investigator who was indicted in the U.S. District Court in Greenbelt, Maryland for making false statements. On August 4, 2008, he was sentenced to 10 months of home detention as part of a three-year period of supervised probation. Prior to sentencing, he paid full restitution of \$101,032 to OPM. Restitution included the cost of reinvestigating the cases he falsified, his salary for this period, and FISD administrative expenses.



The former background investigator was charged with fabricating and falsifying at least four background investigation interview reports provided to FISD from 2005 through mid-2006. In the plea agreement, he admitted that he fabricated information in a background investigation report which stated that he had interviewed three individuals. He also admitted that he falsely claimed to have reviewed certain documents in connection with the report.

OPM estimates that he provided false information in 30 of the 67 background investigations he was assigned to conduct.

Former OPM Contractor Employee Confesses to Falsification of Background Records

A former Washington, D.C. area OPM background investigator, employed by U.S. Investigations Services, a contracting firm that conducts background investigations for FISD, plead guilty in June 2008 to making a false statement. He was sentenced to 180 days of home detention as part of a one-year period of supervised probation and ordered to pay \$10,000 in restitution to OPM.

Between October 2007 and February 2008, in at least six background investigations, he reported interviews with individuals he never met. He also stated that he had, on at least five occasions, reviewed records, which he never did. In addition, in doing his background investigations, he fabricated or falsified answers to questions that he had forgotten to ask during the interviews.

Falsified or inaccurate information provided by a background investigator may result in breaches in national security, or employment of unsuitable individuals. FISD is required to reopen and reinvestigate numerous background investigations because of the investigator's fabrications.

Life Insurance Fraud Results in Conviction and Restitution

Under the Federal Employees' Group Life Insurance (FEGLI) Program, Federal employees and retirees can elect to take a living benefit based on a life threatening illness. Eligible individuals who apply and qualify for the FEGLI living benefit may receive a full or partial payment of their life insurance.

In our semiannual report ending March 31, 2008, we reported that the son of a former Federal employee pled guilty to making a false statement and submitting fraudulent documents to obtain his elderly father's life insurance benefits from the FEGLI Program. Our investigation found that the son submitted fraudulent documentation which allowed the living benefit to be paid for his father, a retired Federal employee. We determined that the father was not terminally ill.

The son, a registered nurse who had a drug addiction, misled his father to believe that he could borrow against his Federal life insurance to purchase a car. In the documentation supplied to receive the benefit, the son created a fictitious physician to certify the diagnosis of terminal colon cancer. He also forged his father's signature to negotiate the insurance check. The son used the \$22,824 insurance benefit to support his drug habit.

In June 2008, the son was sentenced to 48 months probation and ordered to pay \$22,824 in restitution.

This case was referred to our office by the Metropolitan Life Insurance Company, the FEGLI contractor, after they received a complaint from other family members. After our investigation, it was determined that the elderly father's benefits would be reinstated.



OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's Health Care Fraud Hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 576 formal complaints and calls on these hotlines during the reporting period. The table on page 30 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 channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 196 contacts, including telephone calls, 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 carriers. Each caller receives a follow-up call or letter from the OIG hotline coordinator, the insurance carrier, or another OPM office as appropriate.

The Health Care Fraud Hotline received 383 complaints during this reporting period, including both telephone calls and letters.

OIG-Initiated Complaints

We initiate our own inquiries by looking at OPM's automated systems for possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance. Our office will open an investigation, if complaints and inquiries can justify further action.

An example of a complaint that our office will initiate involves retirement fraud. When information generated by OPM's automated annuity roll systems reflects irregularities such as questionable payments to annuitants, we determine whether there are sufficient grounds to justify an investigation. At that point, we may initiate personal contact with the annuitant to determine if further investigative activity is warranted.

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



Administrative Sanctions of 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 30,603 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 498 administrative sanctions—including both suspensions and debarments—of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 1,978 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.

Illinois Dental Practice Debarred

In June 2008, we debarred a dental practice owned by a dentist who was previously debarred by our office. Our debarment was the result of her exclusion by another Federal agency for a default on a Health Education Assistance Loan. Under the FEHBP sanctions statute, the debarring official may debar an entity based upon its ownership or control by a sanctioned individual.

One of our FEHBP carriers referred this case to our office upon discovering that the debarred dentist was submitting FEHBP claims under the practice name. We view this method of filing claims as an attempt by the debarred provider to circumvent her debarment and continue to receive FEHBP payments to which she is not entitled. The debarment of his Illinois dental practice is for an indefinite period pending reinstatement of the debarred dentist.



Utah Physician and his Medical Practice Debarred after Physician Surrenders Medical License

In April 2008, our office debarred a Utah physician and his medical practice for an indefinite period. The physician participated in FEHBP plans as a provider of medical services. An FEHBP carrier made this referral to us after reading a December 2007 newspaper article regarding the indictment of the physician, known by some patients as the “candy man.”

The indictment alleged that the physician wrote illegal prescriptions for painkillers for up to 80 individuals per day. He is accused of contributing to the deaths of five patients, because these individuals used a mixture of drugs containing at least a Schedule II Controlled Substance that the physician gave or prescribed to them.

The FEHBP carrier further determined that the physician had voluntarily surrendered his medical license without admitting or denying allegations contained in the Emergency Order issued by the Utah Medical Board. The Emergency Order alleged, among other offenses, that the physician prescribed drugs and controlled substances in violation of professional standards of practice. He engaged in:

- inappropriate pain management;
- inappropriate prescribing practices; and,
- actions and communications which were false, misleading, deceptive and/or fraudulent.

We may debar health care providers that have surrendered their professional license while a formal disciplinary proceeding is pending before a state licensing authority. Additionally, under our authority, we may debar an entity based upon its ownership or control by a debarred individual.

Louisiana Cardiologist and Practices Suspended After Indictment

In August 2008, our office suspended a Louisiana cardiologist and two medical facilities he owns, based on the cardiologist’s indictment for 92 counts of health care fraud. The OIG’s Office of Investigations referred this case to the administrative sanctions staff. We reported the cardiologist’s indictment in the OIG semi-annual report for the period ending March 31, 2008.

The indictment alleges that the cardiologist:

- performed medically unnecessary angioplasty procedures, and placed stents in arteries that had insignificant disease;
- placed stents in vessels with little or no stenosis (a narrowing or constriction of the diameter of a bodily passage or orifice) in the artery;
- falsely claimed that certain medical services and related medical supplies were provided to recipients in accordance with health care benefit program agreements; and,
- attempted to justify and to support the fraudulent claims by:
 - creating false and fraudulent records;
 - making false entries in records, including cardiac catheterization reports by falsifying the amount of stenosis in test results; and,
 - making fictitious diagnoses, and fabricating entries in operative reports and other documents contained in the patients’ files.

The actions of the cardiologist clearly placed his patients’ health and safety at risk. Additionally, he defrauded healthcare benefits programs of approximately \$2.5 million from 2001 through 2004. The suspensions of the cardiologist and his two medical practices are for an indefinite period pending the outcome of his trial.



West Virginia Osteopath Suspended After Indictment

In May 2008, we suspended a doctor of osteopathic medicine after he was indicted on 42 counts of conspiracy to sell, distribute, and/or dispense controlled substances.

The doctor was employed as an emergency medicine physician at a hospital in West Virginia. We identified this case through our e-debarment research. We determined that the doctor appears as a preferred provider of health care services for several FEHBP carrier networks.

The indictment alleges that the doctor, in exchange for sexual favors:

- conspired with individuals to illegally obtain possession of Hydrocodone, a Schedule III controlled substance, and Oxycodone, a Schedule II controlled substance, by misrepresentation, fraud, deception, and subterfuge;
- distributed 32 prescriptions of Oxycodone to an individual under her father's name;
- distributed two prescriptions of Oxycodone to the same individual in the name of the individual's mother; and,
- distributed five prescriptions of Oxycodone to another individual in the name of the individual's husband.

The doctor's actions clearly pose a risk to the health and safety of his patients. His suspension is for an indefinite period, pending the outcome of his trial.

Maryland Physician Suspended

In August 2008, we suspended an internal medicine specialist after the Maryland Board of Physicians temporarily suspended his license. The board determined probable cause existed that the physician sexually assaulted two female patients while performing physical examinations at his clinic. The board took action against the doctor after his indictment for rape and assault-related violations. The board further concluded that his continued practice of medicine would place the health, safety or welfare of the public at risk.

In addition to Maryland, the doctor is licensed in the District of Columbia, Virginia and Tennessee. At the time we suspended him, his Tennessee license was still active.

We identified this case through our e-debarment research and, subsequently, determined that he had regularly submitted claims to two major fee-for-service FEHBP carriers. We determined his conduct poses an immediate risk to the safety and well-being of FEHBP enrollees.

The duration of his suspension is pending issuance of a further order by the Maryland Board of Physicians.

Kansas Osteopath and Wife Suspended

In May 2008, we suspended a Kansas osteopath and subsequently suspended his wife. The two were indicted by a Federal grand jury, in December 2007, on 34 counts, including:

- five counts of controlled substances violations which resulted in bodily harm; and,
- eleven counts of health care fraud.



The alleged offenses were committed from 2002 through 2007. During that period, 56 of his patients died of accidental drug overdoses.

The doctor, known on the street as the “pill man” and the “candy man,” and his wife:

- illegally distributed and indiscriminately prescribed highly addictive controlled substances;
- submitted fraudulent claims to private and Federal health care programs;
- ignored red flags that patients were either abusing their medications or diverting them; and,
- failed to maintain adequate patient records and document the medical justification for prescribing the drugs in question.

The doctor and his wife owned and operated a clinic.

The wife, a licensed practical nurse, was the general manager of the clinic, which was used to conduct their illegal activities. Open 7 days a week, sometimes 11 hours a day, its emphasis was on patient volume rather than quality of patient care. According to the indictment, almost 63 percent of the clinic’s income was generated from patients’ office visits for treatments categorized as “pain management.”

Although initially denied bail, the doctor has since been released and is awaiting trial. However, his wife, who was considered a flight risk, remains incarcerated.

In January 2008, the Kansas Board of Healing Arts suspended the doctor’s medical license. The suspensions are indefinite pending outcome of the trials.

The case was referred to OIG by an FEHBP carrier.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Judicial Actions:

Arrests	25
Indictments and Informations	24
Convictions	22

Judicial Recoveries:

Fines, Penalties, Restitutions and Settlements	\$17,355,792
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Retirement and Special Investigations Hotline and Complaint Activity:

Retained for Further Inquiry	31
Referred to:	
OPM Program Offices	79
Other Federal Agencies	86
Total	196

Health Care Fraud Hotline and Complaint Activity:

Retained for Further Inquiry	93
Referred to:	
OPM Program Offices	86
Other Federal/State Agencies	109
FEHBP Insurance Carriers or Providers	95
Total	383

Total Hotline Contacts and Complaint Activity	579
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Administrative Sanctions Activity:

Debarments and Suspensions Issued	498
Health Care Provider Debarment and Suspension Inquiries	1,978
Debarments and Suspensions in Effect at End of Reporting Period	30,603



APPENDICES

APPENDIX I Final Reports Issued With Questioned Costs

April 1, 2008 to September 30, 2008

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	19	\$33,016,377
B. Reports issued during the reporting period with findings	29	44,137,286
Subtotals (A+B)	48	77,153,663
C. Reports for which a management decision was made during the reporting period:	33	42,888,800
1. Disallowed costs	–	43,171,573
2. Costs not disallowed	–	(282,773) ¹
D. Reports for which no management decision has been made by the end of the reporting period	15	34,264,863
E. Reports for which no management decision has been made within 6 months of issuance	0	0

¹Represents the net of allowed costs, which includes overpayments and underpayments to insurance carriers.



APPENDIX II

Final Reports Issued With Recommendations for Better Use of Funds

April 1, 2008 to September 30, 2008

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	11	\$745,098
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	11	745,098
C. Reports for which a management decision was made during the reporting period:	5	340,897
1. Disallowed costs	–	340,897
2. Costs not disallowed	–	0
D. Reports for which no management decision has been made by the end of the reporting period	6	404,201
E. Reports for which no management decision has been made within 6 months of issuance	6	404,201



APPENDIX III

Insurance Audit Reports Issued

April 1, 2008 to September 30, 2008

Report Number	Subject	Date Issued	Questioned Costs
1C-TE-00-06-078	ConnectiCare, Inc. in Farmington, Connecticut	April 1, 2008	\$ 0
1A-10-56-07-024	BlueCross BlueShield of Arizona in Phoenix, Arizona April 4, 2008	April 4, 2008	813,540
1C-EG-00-07-059	M-Care in Southfield, Michigan	April 4, 2008	710,440
1C-WD-00-06-081	Dean Health Plan, Inc. in Madison, Wisconsin	April 15, 2008	1,549,398
1C-S4-00-07-060	Keystone Health Plan Central in Harrisburg, Pennsylvania	April 15, 2008	430,192
1C-GA-00-08-005	MVP Health Plan, Inc. Eastern Region in Schenectady, New York	May 5, 2008	1,455,778
1C-J6-00-07-006	Vytra Health Plans in New York, New York	May 9, 2008	120,583
1C-62-00-07-019	Kaiser Foundation Health Plan of Southern California Region in Pasadena, California	May 28, 2008	1,874,425
1C-59-00-07-018	Kaiser Foundation Health Plan of Northern California Region in Pasadena, California	May 28, 2008	1,988,953
1C-LB-00-08-017	Health Net of California in Woodland Hills, California	May 28, 2008	0
1C-MX-00-08-006	MVP Health Plan, Inc. in Schenectady, New York	June 3, 2008	971,071
1C-6Y-00-06-039	Advantage Health Solution, Inc. in Indianapolis, Indiana	June 3, 2008	113,454
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana	June 12, 2008	671,800
1C-2X-00-08-019	Aetna Open Access – Los Angeles and San Diego, California in Blue Bell, Pennsylvania	June 16, 2008	0
1C-FK-00-06-084	AmeriHealth HMO in Iselin, New Jersey	June 16, 2008	0
1A-10-54-07-027	Mountain State BlueCross BlueShield in Parkersburg, West Virginia	June 25, 2008	37,843



APPENDIX III

Insurance Audit Reports Issued

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1A-10-01-07-058	Empire BlueCross BlueShield in Albany, New York	June 25, 2008	\$ 342,373
1C-SV-00-07-056	Coventry Health Care of Iowa, Inc. in St. Louis, Missouri	June 25, 2008	3,319,094
1A-99-00-08-007	Global Coordination of Benefits for BlueCross and BlueShield Plans Contract Year 2006 in Washington, D.C.	June 25, 2008	2,558,643
1C-K5-00-08-051	BlueCare Network of Michigan (East Region) in Southfield, Michigan Proposed Rate Reconciliation	June 26, 2008	0
1C-LN-00-08-054	BlueCare Network of Michigan (Mid Region) in Southfield, Michigan Proposed Rate Reconciliation	June 30, 2008	8,224
1C-51-00-08-055	Health Insurance Plan of New York in New York, New York Proposed Rate Reconciliation	July 2, 2008	0
1C-CA-00-08-052	United Healthcare of Ohio, Inc. (Columbus area) in Hartford, Connecticut Proposed Rate Reconciliation	July 2, 2008	0
1C-AK-00-08-050	United Healthcare of Ohio, Inc. (Cleveland and Toledo area) in Hartford, Connecticut Proposed Rate Reconciliation	July 9, 2008	0
1C-EA-00-07-057	Capital Health Plan in Tallahassee, Florida	July 15, 2008	496,959
1C-8J-00-08-020	Aetna Open Access-Seattle and Puget Sound, Washington in Blue Bell, Pennsylvania	July 16, 2008	227,056
1C-ML-00-08-060	AvMed Health Plan in Gainesville, Florida Proposed Rate Reconciliation	July 23, 2008	0
1C-A3-00-06-085	PacifiCare of Arizona in Cypress, California	July 25, 2008	1,963,727



APPENDIX III

Insurance Audit Reports Issued

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1C-8W-00-07-028	UPMC Health Plan in Pittsburgh, Pennsylvania	July 25, 2008	\$ 5,413,611
1C-Q8-00-08-053	Univera Healthcare in Buffalo, New York Proposed Rate Reconciliation	August 1, 2008	0
1G-LT-00-07-055	Long Term Care Partners, LLC in Portsmouth, New Hampshire	August 4, 2008	1,543,627
1C-U2-00-07-002	Paramount Health Care in Maumee, Ohio	August 7, 2008	267,762
1A-99-00-08-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	August 11, 2008	3,366,080
1A-99-00-07-043	Health Care Service Corporation in Chicago, Illinois, and Richardson, Texas	September 5, 2008	6,522,027
1A-99-00-08-008	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.	September 11, 2008	2,658,529
1C-6Q-00-07-029	Universal Care, Inc. of California in Signal Hill, California	September 15, 2008	2,202,630
1C-7Z-00-08-011	PacifiCare of Oregon in Cypress, California	September 15, 2008	47,375
1C-QA-00-08-027	Independent Health Association in Buffalo, New York	September 29, 2008	301,311
1H-01-00-04-102	BlueCross BlueShield Retail Pharmacy Drug Program Operations at AdvancePCS in Scottsdale, Arizona	September 29, 2008	0
1H-01-00-06-040	BlueCross BlueShield Retail Pharmacy Drug Program Operations at AdvancePCS in Scottsdale, Arizona	September 29, 2008	2,160,781
Totals			\$44,137,286



APPENDIX IV

Internal Audit Reports Issued

April 1, 2008 to September 30, 2008

Report Number	Subject	Date Issued
4A-CF-00-07-062	Office of Personnel Management's Implementation of the Office of Management and Budget Circular A-123, Appendix A	June 23, 2008
4A-CA-00-07-054	Agreement between the Office of Personnel Management and the National Archives and Records Administration for the Storage and Servicing of Records	August 26, 2008
4A-OD-00-06-019	Office of Personnel Management's Office of Combined Federal Campaign Operations	August 29, 2008

APPENDIX V

Information Systems Audit Reports Issued

April 1, 2008 to September 30, 2008

Report Number	Subject	Date Issued
4A-RI-00-08-023	Information Technology Security Controls of the Office of Personnel Management's Employee Benefits Information System, Fiscal Year 2008	April 10, 2008
4A-WR-00-08-024	Information Technology Security Controls of the Office of Personnel Management's Central Personnel Data File	April 17, 2008
1A-10-11-08-001	Information Systems General and Application Controls at BlueCross BlueShield of Massachusetts in Boston, Massachusetts	May 28, 2008
4A-HR-00-08-058	Information Technology Security Controls of the Office of Personnel Management's USAJOBS System	September 5, 2008
4A-MO-00-08-059	Information Systems General and Application Controls of the Office of Personnel Management's Executive Schedule C System, FY 2008	September 8, 2008
4A-CI-00-08-061	Fiscal Year 2008 Federal Information Security Management Act Follow-up	September 16, 2008
4A-CI-00-08-022	Federal Information Security Management Act – Fiscal Year 2008	September 23, 2008

APPENDIX VI

Combined Federal Campaign Audit Report Issued

April 1, 2008 to September 30, 2008

Report Number	Subject	Date Issued
3A-CF-00-07-038	The 2004 and 2005 South Jersey Combined Federal Campaigns in Rancocas, New Jersey	July 24, 2008



APPENDIX VII

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

April 1, 2008 to September 30, 2008

Report Number	Subject	Date Issued
1A-10-15-02-007	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 13 total recommendations; 2 open recommendations	October 1, 2002
1A-10-00-03-013	Global Coordination of Benefits (Tier 1) for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 31, 2004
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 19 total recommendations; 7 open recommendations	May 3, 2004
1A-10-18-03-003	Anthem BlueCross BlueShield of Ohio in Mason, Ohio; 2 total recommendations; 1 open recommendation	May 4, 2004
1A-10-29-02-047	BlueCross BlueShield of Texas in Dallas, Texas; 13 total recommendations; 3 open recommendations	July 28, 2004
1A-10-61-04-009	Anthem BlueCross BlueShield of Nevada in Reno, Nevada; 5 total recommendations; 2 open recommendations	August 2, 2004
4A-RI-00-02-071	Internal Controls over Non-Recurring Payment Actions in the Retirement Services Program; 6 total recommendations; 1 open recommendation	November 2, 2004
1A-10-00-03-102	Global Coordination of Benefits (Tier 2) for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	November 9, 2004
1A-10-45-03-012	Anthem BlueCross BlueShield of Kentucky in Mason, Ohio and Indianapolis, Indiana; 4 total recommendations; 1 open recommendation	November 17, 2004
1A-10-55-04-010	Independence BlueCross in Philadelphia, Pennsylvania; 5 total recommendations; 2 open recommendations	December 15, 2004
4A-OD-00-05-013	Office of Personnel Management's Information Technology Security Controls of the Enterprise Human Resource Integration; 10 total recommendations; 1 open recommendation	May 9, 2005
4A-IS-00-05-026	Office of Personnel Management's Information Technology Security Controls of the Electronic Questionnaire for Investigative Processing; 20 total recommendations; 2 open recommendations	June 16, 2005
1D-80-00-04-058	Group Health Incorporated in New York, New York; 21 total recommendations; 7 open recommendations	June 20, 2005
1A-10-85-04-007	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	July 27, 2005
1A-10-83-05-002	BlueCross BlueShield of Oklahoma in Tulsa, Oklahoma; 16 total recommendations; 2 open recommendations	October 17, 2005



APPENDIX VII

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

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued
1A-99-00-04-027	Global Duplicate Claim Payment for BlueCross and BlueShield Plans in Washington, D.C.; 1 total recommendation; 1 open recommendation	February 7, 2006
1A-10-32-05-034	BlueCross BlueShield of Michigan in Detroit, Michigan; 12 total recommendations; 1 open recommendation	March 24, 2006
1G-LT-00-05-080	Long Term Care Partners, LLC in Portsmouth, New Hampshire; 7 total recommendations; 2 open recommendations	May 17, 2006
1A-10-47-05-009	BlueCross BlueShield of Wisconsin in Milwaukee, Wisconsin; 6 total recommendations; 2 open recommendations	June 5, 2006
3A-CF-00-04-038	The 2001 and 2002 Combined Federal Campaigns for Central Maryland in Baltimore, Maryland; 17 total recommendations; 12 open recommendations	June 6, 2006
1A-10-11-04-065	BlueCross BlueShield of Massachusetts in Boston, Massachusetts; 14 total recommendations; 2 open recommendations	June 26, 2006
3A-CF-00-05-042	The 2002 and 2003 Combined Federal Campaigns for Northern Nevada in Las Vegas, Nevada; 11 total recommendations; 7 open recommendations	July 3, 2006
3A-CF-00-05-039	The 2002 and 2003 Combined Federal Campaigns for Southern Nevada in Las Vegas, Nevada; 11 total recommendations; 6 open recommendations	July 3, 2006
3A-CF-00-05-079	The 2003 Combined Federal Campaign Activities for the Medical Research Charities Federation in Springfield, Virginia; 2 total recommendations; 2 open recommendations	July 14, 2006
3A-CF-00-05-049	The 2002 and 2003 Combined Federal Campaigns for the Research Triangle Area in Morrisville, North Carolina; 16 total recommendations; 9 open recommendations	August 10, 2006
3A-CF-00-05-076	The 2002 and 2003 Combined Federal Campaigns for Central Texas in Austin, Texas; 18 total recommendations; 5 open recommendations	August 14, 2006
4A-IS-00-06-021	Information Technology Security Controls of the Office of Personnel Management's Fingerprint Transaction System; 7 total recommendations; 2 open recommendations	August 29, 2006
1A-10-78-05-005	BlueCross BlueShield of Minnesota in Eagan, Minnesota; 11 total recommendations; 1 open recommendation	September 15, 2006
4A-CI-00-06-016	Federal Information Security Management Act for Fiscal Year 2006; 12 total recommendations; 1 open recommendation	September 22, 2006



APPENDIX VII

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

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued
3A-CF-00-05-040	The 2002 and 2003 Combined Federal Campaigns for San Bernardino in San Bernardino, California; 19 total recommendations; 16 open recommendations	December 26, 2006
1A-10-69-06-025	Regence BlueShield of Washington in Seattle, Washington; 2 recommendations; 1 open recommendation	January 3, 2007
4A-CI-00-07-015	The Privacy Program at the Office of Personnel Management; 7 total recommendations; 3 open recommendations	January 25, 2007
1A-10-58-06-038	Regence BlueCross BlueShield of Oregon in Portland, Oregon; 5 total recommendations; 2 open recommendations	January 31, 2007
1B-31-00-06-044	Government Employees Health Association in Lee's Summit, Missouri; 5 total recommendations; 4 open recommendations	February 6, 2007
1A-10-09-05-087	BlueCross BlueShield of Alabama in Birmingham, Alabama; 14 total recommendations; 3 open recommendations	February 27, 2007
1A-99-00-05-023	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	March 29, 2007
3A-CF-00-05-075	The 2002 and 2003 Combined Federal Campaigns for the Smoky Mountain Region in Knoxville, Tennessee; 21 total recommendations; 6 open recommendations	March 30, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at the Office of Personnel Management; 12 total recommendations; 8 open recommendations	April 16, 2007
1A-10-30-05-069	WellPoint BlueCross BlueShield of Colorado in Mason, Ohio; 18 total recommendations; 5 open recommendations	April 25, 2007
1B-47-00-06-072	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland; 46 total recommendations; 3 open recommendations	May 18, 2007
1A-10-03-06-079	BlueCross BlueShield of New Mexico in Albuquerque, New Mexico; 6 total recommendations; 3 open recommendations	June 5, 2007
3A-CF-00-06-074	The 2004 Combined Federal Campaign Activities for the National Black United Federation of Charities in Newark, New Jersey; 8 total recommendations; 8 open recommendations	July 5, 2007
3A-CF-00-06-060	The 2003 and 2004 Combined Federal Campaigns for Long Island in Deer Park, New York; 12 total recommendations; 4 open recommendations	July 17, 2007



APPENDIX VII

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

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued
1A-10-15-05-046	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 11 total recommendations; 2 open recommendations	July 25, 2007
3A-CF-00-06-061	The 2003 and 2004 Combined Federal Campaigns of the Niagara Frontier Area in Buffalo, New York; 14 total recommendations; 9 open recommendations	July 25, 2007
1D-R5-00-06-069	Federal Blue HMO in Mason, Ohio; 19 total recommendations; 11 open recommendations	July 25, 2007
3A-CF-00-06-051	The 2003 and 2004 Combined Federal Campaigns for the Mid-South in Memphis, Tennessee; 13 total recommendations; 11 open recommendations	July 26, 2007
3A-CF-00-06-056	The 2003 and 2004 Combined Federal Campaigns for Central Iowa in Des Moines, Iowa; 7 total recommendations; 7 open recommendations	August 28, 2007
1A-10-33-06-037	BlueCross BlueShield of North Carolina in Durham, North Carolina; 19 total recommendations; 5 open recommendations	August 28, 2007
4A-CI-00-07-007	Federal Information Security Management Act for Fiscal Year 2007; 9 total recommendations; 3 open recommendations	September 18, 2007
4A-CI-00-07-008	Federal Information Security Management Act Follow-up for Fiscal Year 2007; 13 total recommendations; 5 open recommendations	September 18, 2007
1G-LT-00-07-005	Long Term Care Partners, LLC in Portsmouth, New Hampshire; 3 total recommendations; 3 open recommendations	September 26, 2007
1A-10-41-06-054	BlueCross BlueShield of Florida in Jacksonville, Florida; 11 total recommendations; 4 open recommendations	October 12, 2007
1C-RL-00-06-026	Grand Valley Health Plan in Grand Rapids, Michigan; 3 total recommendations; 3 open recommendations	October 19, 2007
3A-CF-00-06-050	The 2003 and 2004 San Diego County Combined Federal Campaigns in San Diego, California; 11 total recommendations; 3 open recommendations	November 13, 2007
3A-CF-00-06-059	The 2003 and 2004 Combined Federal Campaigns of Cocoa-Brevard County in Cocoa, Florida; 11 total recommendations; 2 open recommendations	November 13, 2007
4A-CF-00-07-034	Office of Personnel Management's Fiscal Year 2007 Consolidated Financial Statements; 3 total recommendations; 3 open recommendations	November 14, 2007



APPENDIX VII

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

April 1, 2008 to September 30, 2008

(Continued)

Report Number	Subject	Date Issued
1A-10-05-06-008	WellPoint BlueCross BlueShield of Georgia in Atlanta, Georgia; 15 total recommendations; 2 open recommendations	November 16, 2007
1A-10-40-07-022	BlueCross BlueShield of Mississippi in Jackson, Mississippi; 6 total recommendations; 2 open recommendations	December 14, 2007
1A-10-42-07-004	BlueCross BlueShield of Kansas City in Kansas City, Missouri; 5 total recommendations; 2 open recommendations	December 14, 2007
3A-CF-00-06-067	The 2003 and 2004 Combined Federal Campaigns for the Coastal Georgia Area in Savannah, Georgia; 11 total recommendations; 5 open recommendations	January 4, 2008
3A-CF-00-06-057	The 2003 and 2004 Combined Federal Campaigns for Northern New Jersey in Newark, New Jersey; 10 total recommendations; 1 open recommendation	January 4, 2008
1A-10-84-07-023	Excellus BlueCross BlueShield in Utica, New York; 4 total recommendations; 2 open recommendations	January 16, 2007
1A-10-07-07-016	BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana; 13 total recommendations; 2 open recommendations	January 18, 2008
1C-3U-00-05-085	UnitedHealthcare of Ohio, Inc. in Hartford, Connecticut; 2 total recommendations; 2 open recommendations	January 18, 2008
1A-10-18-06-052	Anthem Midwest in Mason, Ohio; 16 total recommendations; 2 open recommendations	February 20, 2008
4A-CI-00-06-041	The Office of Personnel Management's Post-Most Efficient Organization Review of the Network Management Group Competition in Washington, D.C.; 2 total recommendations; 2 open recommendations	February 20, 2008
4A-CI-00-06-031	The Office of Personnel Management's Compliance with Federal Tax Laws in Washington, D.C.; 9 total recommendations; 5 open recommendations	February 27, 2008
4A-RI-00-05-037	The Office of Personnel Management's Reclamation Process in Washington, D.C.; 10 total recommendations; 10 open recommendations	March 18, 2008
1A-10-99-06-001	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	March 20, 2008
1D-89-00-06-043	Triple-S, Inc. in San Juan, Puerto Rico; 20 total recommendations; 4 open recommendations	March 26, 2008



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

Section 4 (a) (2):	Review of legislation and regulations	No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies	2-29
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies.	2-14
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	15-24
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	33-36
Section 5 (a) (7):	Summary of particularly significant reports	2-14
Section 5 (a) (8):	Audit reports containing questioned costs	33-35
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	37-41
Section 5 (a) (11):	Significant revised management decisions during this reporting period.	No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period	No Activity



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