

OFFICE
of the
INSPECTOR
GENERAL

*Semiannual Report
to Congress*

Theodore Roosevelt

COMMISSIONER

UNITED STATES CIVIL SERVICE COMMISSION

MAY 13, 1889 – MAY 5, 1895

OCTOBER 1, 2006 *through* MARCH 31, 2007



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

OFFICE OF THE INSPECTOR GENERAL



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$36,872,312
Management Commitments to Recover Funds	\$27,795,093
Recoveries Through Investigative Actions	\$106,464,382

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	31
Inspections Completed	2
Investigative Cases Closed.	68
Indictments and Informations	25
Arrests	25 ¹
Convictions	23
Hotline Contacts and Complaint Activity	572
Health Care Provider Debarments and Suspensions	404
Health Care Provider Debarment and Suspension Inquiries	1,324

¹ This includes seven arrests from the Semiannual Report period ending September 30, 2006. These arrests were inadvertently not reported and occurred in one investigation.



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

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The Inspector General's Message

Our office was a primary participant in a large civil health care fraud claims settlement case against Medco Health Solutions, Inc. of Franklin Lakes, New Jersey. Medco is the second largest pharmacy benefit management (PBM) company in the United States and is one of the PBMs managing prescription drug benefits for the Federal Employees Health Benefits Program (FEHBP). The \$155 million settlement in this case included \$137.5 million that directly impacted the FEHBP, of which \$97 million was returned to the trust fund. This settlement represents the largest monetary settlement the Office of the Inspector General has generated as a result of a single investigation. I am extremely proud of the efforts of our staff over the seven years of working this complex investigation, and I want to commend everyone who was involved in the case.

The purpose, however, of this particular IG message is to acknowledge and pay tribute to James G. Sheehan, Associate U.S. Attorney, U.S. Attorney's Office in Philadelphia, Pennsylvania. Jim's expertise and tenacity were paramount in bringing this case to settlement and he has been a central figure on many other FEHBP cases. He is a foremost expert on health care fraud and a top health care fraud prosecutor and has proven to be a tireless ally of this office in its fight against health care fraud.

Jim has been with the U.S. Attorney's Office since 1980 and has been an advocate in fighting health care fraud since 1990. During this time, he has been involved in more than 500 health care fraud cases with settlements of over \$600 million. He will be leaving the U.S. Attorney's Office for a two-year appointment as the New York State Medicaid Inspector General under the Intergovernmental Personnel Act program. New York Governor Eliot Spitzer has nominated him to head up the one-year old office, overseeing the state's \$50 billion Medicaid program.

Jim Sheehan's work ethic personifies professionalism and integrity of the highest order. We wish him the best of luck and hope we will have the opportunity to work with him on cases of mutual interest in the future.

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

Patrick E. McFarland
Inspector General



Mission Statement

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

WE ACCOMPLISH OUR MISSION BY:

- Conducting and supervising audits, evaluations and investigations relating to the programs and operations of 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 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 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 program (FEGLI).

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 290 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 Blue Cross and Blue Shield health plans, but also include experience-rated HMOs.

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

During the current reporting period, we issued 21 final reports on organizations participating in the FEHBP, of which 16 contain recommendations for monetary adjustments in the aggregate amount of \$36.9 million due the FEHBP.

Appendix III (page 28) contains a complete listing of all health plan audit reports issued during this reporting period.



COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 180 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable federal laws and regulations.

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

Community-rated audits focus on ensuring that:

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

Loading is a rate adjustment that the plan makes to a group’s basic benefit package. For example, the FEHBP provides coverage for dependent children until age 22, while the plan’s basic benefit package may provide coverage 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 14 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$17.7 million to the FEHBP.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Rockville, Maryland

Report No. 1C-E3-00-05-063

JANUARY 12, 2007

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. provides comprehensive medical services to its members throughout the Washington, D.C., Baltimore, Maryland, and Northern Virginia areas. This audit of the plan covered contract years 2000 and 2002 through 2005. During this period, the FEHBP paid the plan approximately \$1.95 billion in premiums.

We identified a total of \$4,388,477 in inappropriate health benefit charges to the FEHBP for these periods. In addition, we determined the FEHBP is due \$309,952 for investment income lost as a result of the overcharges.

\$4.7 Million Returned to the FEHBP

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

Kaiser overcharged the FEHBP for:

- residential treatment facility loading in contract years 2002 and 2003.
- physician copayment for 2003 and 2004.
- catastrophic claims in 2005.

Kaiser agreed with the audit findings.



**MD – Individual Practice
Association, Inc.**
Rockville, Maryland
Report No. 1C-JP-00-04-091
MARCH 22, 2007

MD – Individual Practice Association, Inc. (MD IPA) provides comprehensive medical services to its members throughout Washington, D.C. and Maryland, as well as certain areas in Virginia, (Northern Virginia, Roanoke, Richmond, and Tidewater). This audit of the plan covered contract years 2000 through 2004.

***Auditors Question
\$7.4 Million for
Inappropriate Health
Benefit Charges***

During this period, the FEHBP paid the plan approximately \$1.6 billion in premiums.

The audit identified \$5,873,036 in inappropriate health benefit charges to the FEHBP. In addition, we determined the FEHBP is due \$1,613,421 for investment income lost as a result of the overcharges.

The overcharges occurred because the plan:

- applied incorrect trend, benefit change, and retention factors to the FEHBP rates;
- used incorrect enrollment information;
- miscalculated the current FEHBP premium; and,
- failed to give the FEHBP an appropriate premium discount.

MD IPA and the agency are negotiating the findings.

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 or unions. In addition, experience-rated health maintenance organizations fall into this category.

The universe of experience-rated plans currently consists of approximately 110 audit sites. When auditing these plans, our auditors generally focus on three key areas.

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

During this reporting period, we issued seven experience-rated audit reports. In these reports, our auditors recommended that the plans return \$19.1 million in inappropriate charges and lost investment income to the FEHBP.

BLUECROSS BLUESHIELD SERVICE BENEFIT PLAN

The BlueCross BlueShield Association (BCBS Association) administers a fee-for-service plan, known as the Service Benefit Plan, which contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BCBS operations center in Washington, DC. Approximately 59 percent of all FEHBP subscribers are enrolled in BCBS plans.



AUDIT ACTIVITIES

We issued six BlueCross BlueShield experience-rated reports during the reporting period. These experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors noted \$16.5 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 approximately \$10 million of these questioned costs.

For 86 percent of the 24,989 claim lines questioned, there was no information in the BCBS Association's national claims system to identify Medicare as the primary payer when the claims were paid. However, when the Medicare information was subsequently added to this claims system, the BCBS plans did not adjust the patients' prior claims retroactive to the Medicare effective dates. Consequently, these costs continued to be charged to the FEHBP in their entirety.

*Auditors Question
\$9.8 Million for
Coordination of
Benefits Errors*

We determined that the FEHBP was overcharged \$9,824,631 for these COB errors. The BCBS Association and/or plans are working on recovery of these overcharges.

Global Coordination of Benefits for BlueCross and BlueShield Plans

Report No. 1A-99-00-05-023

MARCH 29, 2007

We performed a limited scope audit to determine whether the BlueCross and BlueShield 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 to identify claims for services rendered from October 1, 2002 through December 31, 2003 that were paid in 2003 and potentially not coordinated with Medicare. We determined that 56 of the 63 plan sites did not properly coordinate claim charges with Medicare. As a result, the FEHBP incorrectly paid these claims when Medicare was the primary insurer.

BlueCross BlueShield of Alabama

Birmingham, Alabama

Report No. 1A-10-09-05-087

FEBRUARY 27, 2007

Our audit of the FEHBP operations at BlueCross BlueShield of Alabama covered health benefit payments for 2002 through 2004, miscellaneous payments and credits, administrative expenses, and cash management activities for 2001 through 2004. During the period 2001 through 2004, the plan paid approximately \$1 billion in FEHBP health benefit charges and \$46 million in administrative expenses.

As a result of the audit, our auditors questioned \$3,489,238, consisting of \$1,575,831 in health benefit overcharges, \$822,403 in administrative expense overcharges, and \$1,091,004 in cash management errors. Lost investment income on the questioned charges totaled \$173,396.



The most significant findings were:

- \$1,091,004 because the plan inadvertently transferred FEHBP funds into its corporate account;
- \$602,849 because the plan did not price claims in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit payments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;
- \$902,601 due to other claim overpayment errors;
- \$505,066 for plan employee pension cost overcharges; and,
- \$197,639 for executive compensation overcharges.

*Auditors Question
\$3.5 Million
in Overcharges and
Cash Management Errors*

The BCBS Association has agreed with \$1,268,914 of the questioned charges.

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 one audit report on an employee organization plan during this reporting period, the Government Employees Hospital Association, Inc.

Government Employees Hospital Association, Inc.

Lee's Summit, Missouri

Report No. 1B-31-00-06-044

FEBRUARY 6, 2007

Our audit covered GEHA's FEHBP operations for contract years 2000 through 2005. During this period, GEHA paid approximately \$8.6 billion in health benefit charges and incurred \$433 million in administrative expenses. We reviewed \$41 million in claim payments from 2002 through 2005. We also examined miscellaneous health benefit payments and credits, administrative expenses, and cash management activities for 2000 through 2005.

The audit identified \$2,571,761 in questionable health benefit payments. We found:

- \$1,345,333 in overpayments because claims were not properly coordinated with Medicare as required by the FEHBP contract;
- \$796,605 in overpayments because claims were not paid in accordance with the Omnibus Reconciliation Act of 1990 requirements;
- \$234,556 for claims of ineligible patients;
- \$183,522 in overcharges for duplicate claim payments; and,
- \$11,745 in overcharges for assistant surgeons.

*Auditors Identified
\$2.6 Million in
Questionable Health
Benefits Payments*

Of the questioned charges, GEHA agreed with \$2,214,101.



AUDIT ACTIVITIES

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 the breach of personal information, privacy has emerged as a major management challenge for most Federal agencies. OPM is no exception.

We conduct information systems audits of FEHBP and FEGLI health and life insurance carriers. For FEHBP health insurance carriers, our office examines the computer security and information systems by performing general and application controls audits.

General controls are the policies and procedures that apply to an entity's overall computing environment.

Application controls apply 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.

Also, we audit OPM's computer security environment to ensure that it is designed to prevent unauthorized system access or disclosure of sensitive information protected by the Privacy Act.

Information Systems General and Application Controls at BlueCross BlueShield of Arizona

Phoenix, Arizona

Report No. 1A-10-56-06-007

NOVEMBER 16, 2006

BlueCross BlueShield of Arizona (BCBSAZ) processes the claims of FEHBP subscribers through its facilities located in Phoenix, Arizona. BCBSAZ's contract covers nearly 38,000 current and former federal employees and their families. The FEHBP pays health care premiums of \$164 million annually to this plan.

This was our first information systems audit at BCBSAZ. This audit covered BCBSAZ systems that process FEHBP claims, including the business structure and control environment in which they operate. We also evaluated BCBSAZ's compliance with the Health Insurance Portability and Accountability Act of 1996. We found that BCBSAZ had implemented a number of controls to help promote a secure computing environment. Some of these controls include:



- An adequate risk assessment methodology, entity-wide security policies that are continuously updated, policies controlling the personal use of corporate resources, and a well-documented security management structure.
- Procedures for granting system access, and adequate controls over physical access to the data center and other facilities.
- Firewall security policies, intrusion detection capabilities, anti-virus controls, and an incident response program.
- Adequate procedures for restricting access to system software and controlling system software changes.
- A system development life cycle methodology and controls for managing changes to application software.
- Adequate controls over the accuracy of the claims being input into the claims processing system.
- Controls that prevent claims payments to health care providers that have been debarred from the FEHBP.
- An infrastructure of personnel, policies, and procedures to identify, manage, communicate, and comply with the security, privacy, and electronic transaction requirements of the Health Insurance Portability and Accountability Act.
- Relocate its backup check writing system to a different facility from the primary check writing system.
- Edit procedures to maintain proper control of all checks received by mail until they are secured by the finance department.
- Modify the Explanation of Benefits form to show the Medicare plan allowance.
- Implement edits in the claims processing system to properly process claims involving worker's compensation, FEHBP debarment, pre-certification, and Omnibus Budget Reconciliation Act of 1990 pricing requirements.

Information Systems General and Application Controls at WellPoint, Inc.

Virginia, Maine, New Hampshire,
and Connecticut

Report No. 1A-10-63-06-032

MARCH 12, 2007

This was our first audit of general and application controls at WellPoint. Our scope was limited to the WellPoint health plans that process FEHBP claims for Virginia, Maine, New Hampshire, and Connecticut. These four plans were originally members of Anthem BlueCross BlueShield, Inc.(Anthem). On November 30, 2004, Anthem acquired WellPoint Health Networks and renamed its company WellPoint, Inc.

We focused on the four former Anthem plans because they use the "Streamline" claims processing system, which will become the primary claims processing platform for all WellPoint health plans. Many of the policies and procedures of the four plans we audited apply to the entire corporation.

However, we also found certain information system controls that could be improved, and recommended BCBSAZ:

- Upgrade logical access controls of its claims processing system.
- Enhance physical controls over its contracted off-site storage facility.



AUDIT ACTIVITIES

We found that WellPoint had implemented a number of controls to help promote a secure computing environment. Some of these controls include:

- Policies to establish and support an information security program, an adequate risk assessment methodology, and a well-documented security management structure;
- Adequate controls for accessing the data center and other facilities;
- Appropriate controls for removing access to networks and applications when necessary;
- A process for testing and implementing application software modifications in a controlled environment;
- Regular tests of service continuity plans;
- Adequate controls over the accuracy of the claims being input into the claims processing system; and,
- Compliance with the security, privacy, and electronic transaction requirements of the Health Insurance Portability and Accountability Act.

However, we found that WellPoint could improve its internal control structure, and recommended that the company:

- Enforce its “Identification and Authentication Policy” using local area network and mainframe security software system configurations and implement a procedure for periodically reviewing active network accounts;
- Establish a policy requiring periodic background re-investigations;
- Modify procedures to maintain proper control of all checks received in the mail until they are logged in at the cashier’s office;

- Update its “Information Security Response Plan” to include current employees;
- Correct procedures to ensure that debarred providers are flagged in its provider file; and,
- Improve the Explanation of Benefits presentation to show when subscribers have met their individual calendar year deductible.

WellPoint officials implemented several of our recommendations during the reporting phase of the audit. Wellpoint will provide supporting documentation on corrective actions taken to address the recommendations.

Audit of the Privacy Program at the U.S. Office of Personnel Management Washington, DC Report No. 4A-CI-00-07-015 JANUARY 25, 2007

In response to concerns over recent high-profile data security breaches, the Office of Management and Budget (OMB) issued memorandum M-06-16, requiring that agencies take certain actions to protect personally identifiable information (PII) from unauthorized disclosure. OMB required that agency inspectors general evaluate compliance with the memorandum.

In this context, we also wanted to examine the agency’s compliance with:

- The Privacy Act of 1974, which, like the OMB memorandum, requires agencies to have administrative and security controls to prevent the unauthorized release of PII data.
- Section 522 of the Consolidated Appropriations Act of 2005 (Section 522) which mandates that agencies implement certain administrative controls to protect PII data.



OPM has established a privacy management structure, completed a privacy impact assessment for all applicable OPM systems, and developed a plan to encrypt data stored offsite. However, we found the agency has not:

- Developed adequate privacy-related policies;
- Established a privacy training program;
- Implemented procedures for monitoring its public websites for inadvertent releases of PII; and,

- Provided technical controls, such as full-disk encryption and two-factor authentication of mobile devices.

OPM remains committed to securing its information assets and has agreed with our recommendations to improve controls over PII data. The agency has developed an implementation plan to fully comply with Section 522 and the OMB Memorandum M-06-16 during fiscal year 2007.



Internal Audits

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 fund-raising activities in federal civilian and military workplaces worldwide.

Combined Federal Campaigns are identified by geographical areas that may include only a single city, or encompass several cities or counties. Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. There are prescribed procedures the IPAs must use during their audits. Our review of the IPA's work includes compliance with these procedures.

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 comprised of federal employees nominated by their respective agencies. It organizes the local CFC, determines local charities' eligibility to participate, supervises the activities of the Principal Combined Fund Organization, and resolves issues relating to a local charity's noncompliance with the policies and procedures of the CFC.
- **Principal Combined Fund Organization (PCFO)**
The PCFO is a charitable organization selected by the LFCC to administer the local campaign. 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 an association of local charitable organizations with similar objectives and interests that provides common fundraising and administrative services to its members.

■ ***Individual charities***

Individual charities are non-profit, human health and welfare organizations that provide charitable services in local geographical areas.

During this reporting period, we issued four audit reports of local CFCs. These reports identified numerous violations of regulations and guidelines governing local CFC operations. The most frequently occurring problems were:

■ ***Campaign Expenses***

The PCFOs for three local campaigns charged the 2003 CFC \$78,489 in unsupported and unallowable campaign expenses. Regulations require that they recover expenses as approved by the LFCC, reflecting the actual costs of administering the campaign.

■ ***PCFO Application***

The PCFO application for all four campaigns did not comply with the regulations. Approving applications that do not comply with CFC regulations could result in an ineligible charity serving as the PCFO.

■ ***Local Application Review Process***

For three campaigns reviewed, we found that the LFCC's applicants' eligibility review process for 2003 and 2004 was inadequate. Specifically, the LFCC's review checklist did not sufficiently show that all eligibility requirements were examined during their approval process.

■ ***Appeals Process***

OPM regulations outline a process for charities to appeal a denial of participation to the LFCC. Three of the campaigns we reviewed failed to follow these regulations.

■ ***Untimely Eligibility Decisions***

All four local campaigns did not render eligibility decisions to the local agencies that applied to the 2003 campaign within the timeframe established by OPM regulations.



AUDIT ACTIVITIES

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 audit activity is 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.

OPM's Background Investigations Process Washington, DC **Report No. 4A-IS-00-04-080** FEBRUARY 16, 2007

We conducted an audit of OPM's Background Investigations Process to determine the cause of the backlog of investigations for OPM employees and contractors. Under Executive Order (EO) 10450, "Security Requirements for Government Employment," OPM is mandated to conduct investigations of all competitive service employees, except those exempted by delegated authority. Our review of background investigation case files included the application of suitability guidance for federal employment as outlined in regulations.

Background investigations for OPM employees and contractors are conducted by OPM's Federal Investigative Services Division (FISD). The completed background investigations for OPM employees and contractors are adjudicated by staff from the Center for Security and Emergency Actions (CSEA) to determine suitability for federal employment.

Our audit consisted of reviewing a sample of background investigations for completeness, accuracy, and compliance with laws, regulations, executive orders, and policies and procedures. Our audit

covered background investigations of OPM employees/contractors and its personnel security program during fiscal year 2004.

We identified seven areas of non-compliance with laws and regulations governing personnel security and background investigations, and six areas where internal controls could be improved.

NONCOMPLIANCE WITH LAWS AND REGULATIONS

- Positions designated as "Critical-Sensitive" require that a background investigation be completed prior to commencing employment, unless a waiver is granted. However, we found that some investigations were completed after employment and a waiver was not granted.
- Re-investigations were not performed every five years for Critical-Sensitive positions, as required by regulations.
- Position designations were upgraded to a higher security level; however, the required corresponding background investigation was not performed in a timely manner.
- In October 2004, 1,406 employees, nearly half of OPM's workforce, needed some kind of background investigative action. We found no evidence that a background investigation was performed for 237 of this group.



- Investigations were not scheduled within 14 days after appointment, as required by regulation.
- In one instance, a security clearance was granted prior to the completion of the background investigation.
- OPM information technology computer contractors were not screened for the appropriate security level.

INTERNAL CONTROL WEAKNESSES

- The Official Personnel Folder (OPF) did not contain a certificate of investigation or investigation scheduled notice.
- The FISD Suitability Handbook was not updated and provided to federal agencies to supplement their personnel security programs.
- The performance clauses in OPM’s contract with US Investigations Services (USIS), OPM’s largest background investigation contractor, did not contain provisions to hold the contractor accountable for not meeting timeliness and quality standards.
- OPM position description cover sheets and the Notification of Personnel Action forms were not updated to reflect changes in security levels.
- Background investigations training was not provided to the human resources staff in Boyers, Pennsylvania.
- OPM’s personnel security program policies and procedures were in draft form and not updated or finalized.

The Center For Security And Emergency Actions Has Taken Corrective Actions On Weaknesses Identified By Our Auditors

Except for one finding, OPM has taken corrective action for all areas of non-compliance. CSEA has not

demonstrated that they have identified all contractors with computer responsibilities and cannot document that all contractors have been screened for proper security requirements.

OPM’S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The Chief Financial Officers (CFO) Act of 1990 requires that an audit of OPM’s financial statements be conducted in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. OPM contracted with KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2006. The contract requires that the audit be done in accordance with generally accepted government auditing standards and the Office of Management and Budget bulletin number 06-03, *Audit Requirements for Federal Financial Statements*.

OPM’s consolidated financial statements consist of five reporting entities: retirement program (RP), health and life insurance benefit programs (HBP and LP), the revolving fund (RF), and the salaries and expenses accounts (S&E). The RF programs provide funding for a variety of human resource-related services to other federal agencies, such as pre-employment testing, background investigations, and employee training. The S&E funds provide the resources used by OPM for the administrative costs of the agency.

In performing the audit, KPMG is responsible for issuing an audit report including:

- An opinion on the consolidated financial statements and the individual statements for the three benefit programs;
- A report on internal controls; and,
- A report on compliance with laws and regulations.



AUDIT ACTIVITIES

In connection with the audit contract, we oversee KPMG’s performance of the audit to ensure that it is conducted in accordance with the terms of the contract and in compliance with generally accepted government auditing standards and other related materials.

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings and by reviewing KPMG’s work papers and reports. Our review disclosed no instances where KPMG did not comply with generally accepted government auditing standards.

In addition to the consolidated financial statements, KPMG performed the audit of the special-purpose financial statements (closing package) in accordance with the Department of the Treasury’s Financial Manual Chapter 4700. The Department of the Treasury and the Government Accountability Office use the closing package in preparing and auditing the government-wide Financial Report of the United States.

- Civil Service Retirement System (CSRS)
- Federal Employees Retirement System (FERS)
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees’ Group Life Insurance program (FEGLI)

CONSOLIDATED & BENEFITS PROGRAMS FINANCIAL STATEMENTS

KPMG reported that the fiscal year (FY) 2006 and 2005 consolidated financial statements and the individual statements of the three programs that govern the retirement, health, and life benefits of federal employees and retirees, were presented fairly and in conformity with generally accepted accounting principles. These reviews generally include identifying reportable conditions and material weaknesses.

***OPM Receives
“Clean” Audit Opinion
in FY 2006***

OPM’s FY 2006 Consolidated Financial Statements

Report No. 4A-CF-00-06-045

NOVEMBER 15, 2006

KPMG audited the balance sheets of OPM as of September 30, 2006 and 2005 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the retirement, health and life insurance benefit programs, as of September 30, 2006 and 2005 and the program’s related individual financial statements for those years. The benefits programs, which are essential to the payment of benefits to federal civilian employees, annuitants, and their respective dependents, operate under the following names:

A reportable condition represents a significant deficiency in the design or operation of internal controls that could adversely affect OPM’s ability to record, process, summarize, and report financial data consistent with management assertions in the financial statements.

A material weakness is a condition in which the design or operation of an internal control does not reduce to a relatively low level the risk that misstatements, in amounts that would be material in relation to the financial statements being audited, may occur and not be detected within a timely period.



KPMG reported four reportable conditions and no material weaknesses in the internal controls over financial reporting during FY 2006. Three of the reportable conditions remain unresolved from the prior fiscal year; however, one is new in FY 2006. The reportable conditions identified by KPMG are:

- The Office of Chief Financial Officer (OCFO) needs to strengthen some entity-wide security controls, access controls, and change control processes;
- The OCFO has deficiencies in the ability to record, process, summarize and report financial data for the RF Programs and S&E Funds that may misstate the financial statements;
- OPM's cost accounting system for the RF Programs and S&E Funds is not designed or configured to determine full costs associated with strategic goals and major outcomes; and,

- OPM lacks policies and procedures to validate financial information and assess the internal controls over processing and reporting transactions of the experience-rated and life insurance carriers.

KPMG's report on compliance with laws and regulations disclosed a non-compliance with the Prompt Payment Act and other matters related to the Federal Financial Management Improvement Act of 1996.

No Material Weaknesses Reported in FY 2006

Table 1 includes the reportable conditions that KPMG identified during its audit work on the financial statements for FY 2006 and 2005. OPM agreed to the findings and recommendations reported by KPMG.

TABLE 1: INTERNAL CONTROL WEAKNESSES

Title of Findings From FY 2006 Report	Program/Fund	FY 2005	FY 2006
Information Systems General Control Environment	All	Reportable Condition	Reportable Condition
Managerial Cost Accounting to Determine Full Cost Associated with Strategic Goals and Major Outcomes	RF and S&E	Reportable Condition	Reportable Condition
Financial Information Received from Experience-Rated and Life Insurance Carriers	HBP and LP	Not Reported	Reportable Condition
Financial Management and Reporting Processes of OCFO	RF and S&E	Reportable Condition	Reportable Condition



OPM's FY 2006 Special-Purpose Financial Statements

Report No. 4A-CF-00-07-012

NOVEMBER 17, 2006

The closing package financial statements, also referred to as special-purpose financial statements, are required to be audited in accordance with generally accepted government auditing standards and the provisions of the OMB's Bulletin No. 06 -03. OPM's Closing Package Financial Statements include:

- The reclassified balance sheets (formatted according to Department of the Treasury's specifications);
- The statements of net cost;
- The statement of changes in net position (a statement that explains the changes in the financial status between two fiscal years) and the accompanying notes as of September 30, 2006 and 2005;

- The trading partner balance sheet (shows the funds due between OPM and other agencies); and
- The statement of net cost and the statement of changes in net position as of September 30, 2006. KPMG reported that these statements are fairly presented in all material respects.

KPMG did not identify any material weaknesses or reportable conditions involving the internal controls over the financial process for the special-purpose financial statements.

***No Reportable Conditions
or Material Weaknesses
Reported by KPMG for
FY 2006***



Enforcement

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the CSRS, 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 involving these trust funds.

During the reporting period, our office opened 61 investigations and closed 68, with 282 still in progress at the end of the period. Our investigations led to 25 arrests, 25 indictments and/or informations, 23 convictions and \$106,464,382 in monetary recoveries. For a complete statistical summary of our office's investigative activity, refer to the table on page 26.

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 common.

OIG special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and subscribers. 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 health care providers reveal evidence of violations that may warrant administrative sanctions.



HEALTH CARE FRAUD CASES

Medco Returns \$97 Million to FEHBP in Settlement

In October 2006, Medco Health Solutions, Inc., a pharmacy benefits manager, settled a suit with the United States Government for \$155 million, of which \$137.5 million directly impacted the FEHBP. The pharmacy benefits manager provided mail order prescriptions and related benefit services for federal employees, retirees, and their dependants, pursuant to a contract with an FEHBP insurance carrier. The United States alleged the company:

- falsely reported turnaround performance (a negotiated timeframe for filling prescriptions) under FEHBP carrier contracts;
- dispensed prescriptions without properly performing drug utilization reviews (determining appropriate use of medication);
- falsified paper or electronic records relating to the dispensing process;
- improperly used pharmacy technicians and other non-pharmacist personnel to perform functions which legally must be performed by pharmacists or under a pharmacist's direct supervision; and,
- billed the government for prescriptions that were never filled or ordered.

The FEHBP trust fund received \$97 million out of the \$137.5 million settlement.

\$10 Million Judgment Imposed Against Convicted Texas Physician

In November 2006, a Texas physician was found guilty of mail and health care fraud, and ordered by the court to pay a \$10 million judgment. The physician specialized in the treatment of Hepatitis C patients. He submitted false claims to health care plans for services not rendered, and created false documentation to support the fraudulent medical claims forms. The physician defrauded the FEHBP of over \$2.3 million.

In December 2006, the government seized an investment account valued at \$5.5 million, jewelry, and three properties of an undetermined value. This was a joint investigation between our office, the Federal Bureau of Investigation (FBI) and the Texas Department of Insurance, which began in September 2003. Sentencing is scheduled for July 2007.

Pharmaceutical Off-Label Fraud Criminal and Civil Settlement Nets Over \$6 Million for the FEHBP

Intermune, a bio-technology company that manufactures Actimmune, a drug for the treatment of Cystic Fibrosis, was accused of illegally marketing this drug for a use not approved by the Food and Drug Administration (off-label). In October 2006, to avoid prosecution, the company agreed to a settlement of \$42.5 million. The FEHBP will receive over \$6 million of the settlement to be distributed over a six-year period.

Although the criminal and civil settlements have been finalized, the government continues to investigate some of Intermune's former executives for their conduct during the time the alleged offenses occurred.



RightCHOICE Settles FEHBP False Claims Case

In January 2007, RightCHOICE Managed Care, Inc., agreed to pay the United States \$975,000 to settle a False Claims Act suit. The suit was originally filed against Wellpoint Health Networks, Inc., prior to its merger with RightCHOICE. It alleged that the Wellpoint, which participated in the FEHBP as part of the Blue Cross and Blue Shield Federal Employee Plan (FEP), passed on excessive and unreasonable costs to the FEHBP by paying higher fees to physicians for serving patients insured through the FEP than these same physicians were reimbursed for providing the same types of services to patients insured through various other health plans. The FEHBP recovered \$809,250 from the settlement.

FEHBP Carrier Recovers Additional Funds After Cardiac Monitoring Settlement

In our last semiannual report, we reported that a company performing cardiac monitoring services settled with the United States government for \$637,446 for improper billing practices. Our investigators found that between 2001 and 2004, the company repeatedly billed for five instances of cardiac monitoring per thirty-day service period, although the current procedural terminology code restricts billing to once every thirty-days. The company sent several inquiries to the health insurance carrier concerning the amount of funds they were receiving. The carrier initially failed to detect the problems with the billings and the company never revised their billing practices nor offered any reimbursement to the government. After settlement, at the prodding of the carrier, the provider voluntarily offered to repay additional FEHBP funds of \$435,204.

Pharmacist Convicted in Two States for Prescription Fraud

In November 2006, a Maryland pharmacist, who is a nationalized citizen from Nigeria, pleaded guilty in the federal district of Maryland to prescription fraud. He was sentenced to eight months incarceration. In addition, in March 2007, he pleaded guilty in Virginia to obtaining prescription by fraud. His sentencing in the federal district of Virginia is scheduled for May 2007.

The Montgomery County, Maryland Police Department requested the OPM OIG's assistance in an investigation regarding an FEHBP member whose benefits were being fraudulently used to obtain prescription narcotics. The investigation disclosed that the pharmacist was a previous neighbor of the member. The member vaguely remembered the pharmacist as a neighbor, but was not aware that he was utilizing her benefits to obtain prescription narcotics. As a licensed pharmacist, he had access to pharmacy records. The scheme involved him recording prescriptions into the pharmacy computer as if a doctor called in a prescription for the member.

The unsuspecting doctor, who also was from Nigeria, was not familiar with the member or the pharmacist. The pharmacist used his position of trust to obtain drugs under Controlled Substance Schedule III and IV, including Hydrocodone, Tussionex, Clonazepam, Zoloft and Biaxin. After entering the information into the computer, the pharmacist would transfer the prescription to a different pharmacy. Sometime later, he would pick up the fraudulent prescription posing as a relative of the FEHBP member. The pharmacist persistently requested that the brand name drug be in its original container. He refused any generic drug and any drug not in its original container. A prescription drug cannot be shipped to Nigeria unless it is in its original container.



ENFORCEMENT

This was a joint investigation with our Office of Investigation agents, the Montgomery County Maryland Police Department and the Virginia State Police.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant. Retirement fraud involves intentional receipt and use of CSRS or FERS benefits 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.

Relatives of Deceased Annuitant Sentenced for Mail Fraud, Bankruptcy Fraud

After a survivor annuitant's death, her son and daughter-in-law continued to receive and spend her retirement checks. The relatives declared bankruptcy without disclosing the funds as income in their bankruptcy filing. To continue to receive the deceased survivor annuitant's payments, the

daughter-in-law forged the decedent's signature on correspondence submitted to OPM. From November 1992 until August 2003, they received survivor benefits totaling \$174,444. The son pleaded guilty to bankruptcy fraud and was sentenced to five years probation and restitution of \$11,951. The daughter-in-law pleaded guilty to mail fraud and was sentenced to 24 months incarceration and ordered to restitution of \$174,444 to OPM.

Niece Pleads Guilty in Retirement Fraud Case

In March 2007, the niece of a deceased federal annuitant signed an agreement to plead guilty to theft of government property. Our investigators determined through proactive efforts that the annuitant died in December 1994; however, between 1994 and 2003, the niece illegally received \$159,654 in OPM annuity benefits. Our investigators found that she used the funds for personal gain knowing that she was not entitled to the funds. After her uncle's death, she sold his home and moved to another area of the state.

Part of her first plea was that she did not receive all the funds because her ex-boyfriend took some of the money. In the final plea agreement, the niece is required to pay full restitution. The Department of the Treasury, at OPM's request, recovered \$57,981 from the defendant's bank account, leaving an outstanding balance of \$101,673 in fraudulent overpayments. Sentencing is scheduled for June 2007.

Granddaughter Pleads Guilty in Retirement Fraud Case

A proactive retirement initiative revealed during our routine review of annuity data that a San Francisco annuitant died in October 1986. After the annuitant's death and the failure to report the death



to OPM, benefits continued to be paid directly into a bank account controlled by the annuitant's granddaughter. The granddaughter confessed that she forged her grandmother's signature on OPM documents to illegally receive the funds.

In October 2006, the granddaughter was charged with theft of government property. She pleaded guilty, and was sentenced in December 2006 to three years' probation and ordered to make restitution of \$216,178 to OPM. The first 18 months of her probation will be served under home detention, with a special exception for her to continue to report to work.

Son of Deceased Annuitant Ordered to Repay Double Damages Related to Retirement Fraud

Our investigators found that the son of a deceased annuitant continued to receive benefits after the death of his father. The benefits were deposited into a joint bank account shared by the father and son. He never notified OPM of his father's death nor removed his deceased father's name from the account. The son stated he believed he was entitled to the money.

The Assistant U. S. Attorney declined criminal prosecution, but the Department of Justice filed a Civil False Claims Act suit against the son. The original loss to OPM was \$72,045. Because every deposit to or withdrawal from the joint bank account was considered a separate false claim, the court added penalties for each transaction, totaling \$1,774,090. In January 2007, the District Court Judge ordered the defendant to pay double damages totaling \$144,090, and indicated that if the son defaults on payment, the judgment of \$1,774,090 will go into effect.

Son Pleads Guilty to Theft from Retirement Fund

In February 2007, the son of a CSRS annuitant pleaded guilty to theft of government funds in the District of Columbia. He continued to collect his mother's civil service benefits after he failed to report to OPM that she died in 1984. This resulted in a fraudulent overpayment of \$162,962.

Our investigators found that the son forged his mother's signature on numerous government documents, including his mother's U.S. Treasury checks. He claimed to have used the funds for his children's education, however, evidence showed that only \$10,000 was used for that purpose. The court ordered the son to pay full restitution to OPM. His sentencing hearing was continued until August 2007.

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 572 formal complaints and calls on these hotlines during the reporting period. The table on page 33 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



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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 218 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 354 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 reflect 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 29,828 active suspensions and debarments from FEHBP.

During the reporting period, our office issued 404 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 1,324 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 their health insurance coverage through it. 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.*

California Durable Medical Equipment Supply Company and its Owner Suspended

In February 2007, we suspended a California durable medical equipment supply company and its owner based upon a referral from our Office of Investigations. The case was a joint investigation between our office, the FBI and HHS OIG. The owner was in the business of supplying products



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and services to sleep disorder patients, including Continuous Positive Airway Pressure (CPAP) devices, face masks, hoses, filters and related durable medical equipment. She also provided maintenance services for the equipment.

The owner pleaded guilty to mail fraud in connection with a scheme to defraud patients and their insurance companies by supplying sleep disorder patients with less expensive disposable full-face masks instead of the more expensive reusable masks to which patients were entitled. She engaged in this conduct with at least 10 patients, and caused insurance companies to incur a loss of approximately \$5,000 to \$10,000. We will consider debarment of the owner and company after the owner's sentencing, which is scheduled for April 2007.

- submitted inappropriate charges for durable medical equipment services;
- charged for services (evaluation and management visits) during examination for and the dispensing of durable medical equipment supplies;
- maintained substandard medical records;
- submitted charges for unnecessary services;
- failed to timely provide requested medical records to a patient; and,
- failed to be available for medical care to a patient during an office relocation.

The debarment will be for an indefinite period pending full reinstatement of the podiatrist's license.

Texas Podiatrist Proposed for Debarment

In March 2007, we proposed the debarment of a podiatrist based upon a referral from our Office of Investigations regarding the podiatrist's suspended professional license. The podiatrist has participated as a provider of medical services and supplies in the FEHBP. The license was suspended because the podiatrist violated provisions of the Podiatric Medical Practice Act and various other Texas state codes. He:

- failed to provide biomechanical supporting devices for two patients;
- failed to appropriately treat the acute symptoms for a patient;

Virginia Orthopedist Receives 15 Year Debarment

In a prior semiannual report, we reported our suspension of a Virginia orthopedist based on his indictment in federal court for 91 counts of drug-related violations, including the unlawful distribution and trafficking of controlled substances. The provider pleaded guilty and in April 2006, a judgment was entered against him for one count of conspiracy to traffic in controlled substances. The sentence included 87 months imprisonment and forfeiture of \$497,615 to the federal government.

This violation constitutes a mandatory debarment under OPM's statutory administrative sanctions. Therefore, we proposed to debar the provider from FEHBP participation. In applying our debarment



authority, we noted that the severity of the case was underscored by the presence of numerous aggravating factors. These included the following:

- Significant financial losses incurred by the FEHBP and other federal health care programs as a result of the provider's actions;
- Prolonged and repeated nature of the offenses which involved the provider's unlawful prescribing practices and dispensation of dangerous controlled substances (1999 – 2005);

- Prior record of criminal, civil, or administrative adjudication of related or similar acts; and,
- Risk that was generated for patients resulting from the provider's negligent conduct and the gross carelessness he demonstrated in his practice of medicine.

We debarred the orthopedist for a period of 15 years. The length of the debarment includes the prior period of suspension.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

JUDICIAL ACTIONS:

Arrests	25 ¹
Indictments and Informations	25
Convictions	23

JUDICIAL RECOVERIES:

Fines, Penalties, Restitutions and Settlements	\$106,464,382
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RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	35
Referred to:	
OPM Program Offices	98
Other Federal Agencies	85
Total	218

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	90
Referred to:	
OPM Program Offices	68
Other Federal/State Agencies	52
FEHBP Insurance Carriers or Providers	144
Total	354
Total Hotline Contacts and Complaint Activity	572

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	404
Health Care Provider Debarment and Suspension Inquiries	1,324
Debarments and Suspensions in Effect at End of Reporting Period	29,828

¹ This includes seven arrests from the Semiannual Report period ending September 30, 2006. These arrests were inadvertently not reported and occurred in one investigation.



Appendices

APPENDIX I

FINAL REPORTS ISSUED WITH QUESTIONED COSTS

October 1, 2006 to March 31, 2007

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	6	\$22,509,729
B. Reports issued during the reporting period with findings	16	36,872,312
Subtotals (A+B)	22	59,382,041
C. Reports for which a management decision was made during the reporting period:	10	27,795,093
1. Disallowed costs		26,947,360
2. Costs not disallowed		847,733
D. Reports for which no management decision has been made by the end of the reporting period	12	31,586,948
E. Reports for which no management decision has been made within 6 months of issuance		

APPENDIX II

FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS

October 1, 2006 to March 31, 2007

No activity during this reporting period



OFFICE OF THE INSPECTOR GENERAL

APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

October 1, 2006 to March 31, 2007

Report Number	Audits	Issue Date	Questioned Costs
1C-AH-00-05-022	HMO Blue in Utica, New York	October 5, 2006	\$729,767
1A-10-49-04-072	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey	October 5, 2006	2,222,877
1C-54-00-05-072	Group Health Cooperative in Seattle, Washington	October 26, 2006	
1C-PX-00-05-006	Cimarron Health Plan in Albuquerque, New Mexico	November 1, 2006	1,324,744
1C-2N-00-06-029	PacifiCare of Oklahoma in Cypress, California	November 3, 2006	
1C-63-00-06-030	Kaiser Foundation Health Plan of Hawaii in Honolulu, Hawaii	December 7, 2006	
1A-10-16-06-053	BlueCross BlueShield of Wyoming in Cheyenne, Wyoming	December 7, 2006	16,136
1A-10-69-06-025	Regence BlueShield of Washington in Seattle, Washington	January 3, 2007	58,656
1C-A7-00-05-032	Health Net of Arizona in Woodland Hills, California	January 9, 2007	
1C-E3-00-05-063	Kaiser Foundation Health Plan of the Mid-Atlantic States in Rockville, Maryland	January 12, 2007	4,698,429
1C-D6-00-05-019	PacifiCare of Colorado in Cypress, California	January 19, 2007	66,996
1C-L4-00-05-065	HMO Health Ohio in Cleveland, Ohio	January 19, 2007	1,720,615



APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

October 1, 2006 to March 31, 2007

(Continued)

Report Number	Audits	Issue Date	Questioned Costs
1A-10-58-06-038	Regence BlueCross BlueShield of Oregon in Portland, Oregon	January 31, 2007	\$768,956
1C-7D-00-05-067	Aetna Health Inc. of Ohio in Blue Bell, Pennsylvania	February 6, 2007	962,675
1B-31-00-06-044	Government Employees Health Association in Lee's Summit, Missouri	February 6, 2007	2,571,761
1C-MK-00-06-034	BlueChoice in Rochester, New York	February 8, 2007	
1A-10-09-05-087	BlueCross BlueShield of Alabama in Birmingham, Alabama	February 27, 2007	3,662,634
1C-GV-00-05-073	Preferred Care in Rochester, New York	March 1, 2007	559,705
1C-GE-00-05-070	PersonalCare in Champaign, Illinois	March 1, 2007	197,273
1C-JP-00-04-091	MD-Individual Practice Association, Inc. in Rockville, Maryland	March 22, 2007	7,486,457
1A-99-00-05-023	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	March 29, 2007	9,824,631
TOTALS			\$36,872,312



OFFICE OF THE INSPECTOR GENERAL

APPENDIX IV

INTERNAL AUDIT REPORTS ISSUED

October 1, 2006 to March 31, 2007

Report Number	Subject	Issue Date
4A-CF-00-06-045	Office of Personnel Management's Fiscal Year 2006 Consolidated Financial Statement	November 13, 2006
4A-CF-00-07-021	Office of Personnel Management's Fiscal Year 2006 Closing Package Special Purpose Financial Statement	November 17, 2006
4A-IS-00-04-080	Background Investigations Process for Office of Personnel Management Employees and Contractors in Washington, D.C. and Boyers, Pennsylvania	February 16, 2007

APPENDIX V

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

October 1, 2006 to March 31, 2007

Report Number	Subject	Issue Date
1A-10-56-06-007	Information Systems General and Application Controls at BlueCross BlueShield of Arizona in Phoenix, Arizona	November 16, 2006
4A-CI-00-07-015	The Privacy Program at the Office of Personnel Management in Washington, D.C.	January 25, 2007
1A-10-63-06-032	Information Systems General and Application Controls at Wellpoint, Inc. in Roanoke, Virginia	March 12, 2007



APPENDIX VI
COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED
October 1, 2006 to March 31, 2007

Report Number	Subject	Issue Date
3A-CF-00-05-040	The 2002 and 2003 Combined Federal Campaigns for San Bernardino in San Bernardino, California	December 26, 2006
3A-CF-00-06-062	The 2003 and 2004 Combined Federal Campaigns for the Piedmont Triad in Greensboro, North Carolina	January 18, 2006
3A-CF-00-05-077	The 2002 and 2003 Combined Federal Campaigns for New Hampshire and Southern Maine in Portsmouth, New Hampshire	February 12, 2007
3A-CF-00-05-075	The 2002 and 2003 Combined Federal Campaigns for the Smoky Mountain Region in Knoxville, Tennessee	March 30, 2007



OFFICE OF THE INSPECTOR GENERAL

Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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Section 5 (a) (2): Recommendations regarding significant problems, abuses, and deficiencies 1-16

Section 5 (a) (3): Recommendations described in previous semiannual reports
on which corrective action has not been completed No Activity

Section 5 (a) (4): Matters referred to prosecutive authorities 17-25

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 28-31

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Section 5 (a) (8): Audit reports containing questioned costs 28-31

Section 5 (a) (9): Audit reports containing recommendations for better use of funds No Activity

Section 5 (a) (10): Summary of unresolved audit reports issued prior to the beginning
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Section 5 (a) (11): Significant revised management decisions during this reporting period No Activity

Section 5 (a) (12): Significant management decisions with which OIG disagreed
during this reporting period No Activity



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