Office of the Inspector General

Semiannual Report

TO CONGRESS

October 1, 2000—March 31, 2001

United States Office of Personnel Management

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, D.C. 20415-0001

OFFICE OF
THE INSPECTOR GENERAL

April 30, 2001

Honorable Steven R. Cohen
Acting Director
U.S. Office of Personnel Management
Washington, D.C. 20415

Dear Mr. Cohen:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 2000 to March 31, 2001. This report describes our office's activities during the past six-month reporting period.

Should you have any questions about the report or any other matter of concern, please do not hesitate to call upon me for assistance.

Sincerely,

Patrick E. McFarland
Inspector General

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Message from the IG

It is with a strong sense of "better government" that I take liberty with this message. In so doing, I will not speak of Office of Inspector General (OIG) work per se. Instead, I am asking this Congress and new Administration to consider an outreach effort by the Inspector General (IG) community that would be above and beyond our legislatively mandated responsibilities under the Inspector General Act of 1978.

I propose, by virtue of a Presidential memorandum, that the Inspector General community be permitted to enter into a public/private partnership with the National Center for Missing and Exploited Children. Our cadre of almost 3,000 special agent criminal investigators, with a minimal amount of effort, could provide a unique and benevolent service to American families who have lost their children.

The partnership would be well defined and it is this: The National Center for Missing and Exploited Children presently has a backlog of cases that are referred to as "cold cases," because, unfortunately, police departments throughout the nation have stopped investigating them primarily due to a lack of resources or other priorities. The National Center houses all of these cold cases wherein the child has never been found and/or the suspect has never been identified.

As an example of this proposed partnership I would assign, in my capacity as IG, one of the special agents from my office, workload permitting, to spend a day or two at the National Center in Alexandria,Virginia, reviewing cold cases. The sole purpose for this would be to analyze and review these old cases in an attempt, hopefully, to identify clues that may never have been followed, witnesses that may not have been interviewed, suspects that may not have been pursued, and so forth.

The reevaluated case would then be discussed with National Center personnel, and, once agreed upon, sent back to the police department with primary jurisdiction, along with a letter from the National Center. In that letter, the National Center would strongly encourage the police department to reactivate the cold case based on new findings.

The reopening of a cold case could have monumental results. The best possibility, of course, would be the safe return of a missing child to his or her family. The next best result, sad as it is, would be locating the murdered child. Finally, a result may be identification and arrest of the murderer. As difficult as this is to say and read, we should not forget that the last result does help the family deal with closure.

Hopefully, through our limited involvement, we can help ensure that the National Center will be able to acknowledge to these desperate families that a thorough re-evaluation of their cases has been completed.

So why should the IG community become involved? Why us? I answer it with another question. Why should we not get involved? We have one of the most diverse and talented criminal investigative cadres in the federal government. Indeed, a vast majority of our special agents have come from traditional law enforcement agencies. These individuals have all been highly trained and are extremely capable of dealing with complex, criminal cases. Certainly, our 23-year IG community history has given us the opportunity to illustrate our competence in the area of criminal investigations. When we consider the small amount of time that our IG community would need to invest, with its resources of almost 3,000 special agents, the potential impact of this outreach effort far exceeds the investment.

In closing, I respectfully suggest that the White House look favorably upon the suggestion of a Presidential memorandum as an expeditious way to create a most humanitarian and worthwhile partnership. In 1990, I received a Presidential appointment to be the Inspector General at the U.S. Office of Personnel Management (OPM). From my tenure, and as the chairman of the Investigations Committee of the President's Council on Integrity and Efficiency, I believe the American taxpayer would be pleased and well served by the little effort we would expend in such an outreach endeavor, especially with the potential for success so great.

Productivity Indicators

Financial Impact:

Audit Recommendations for Recovery of Funds $214,341,387

Recoveries Through Investigative Actions $7,082,218

Management Commitments to Recover Funds $59,329,197*

** 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 49

Investigative Cases Closed 19

Cases Accepted for Prosecution 8

Indictments 10

Convictions 10

Hotline Contacts and Complaint Activity 626

Health Care Provider Debarments and Suspensions 2,114

Statutory and Regulatory Review

As is required under section 4 (a)(2) of the Inspector General Act of 1978, as amended, (IG Act) our office monitors and reviews legislative and regulatory proposals for their impact on the Office of the Inspector General (OIG) and the Office of Personnel Management (OPM) programs and operations. Specifically, we perform this activity to evaluate their potential for encouraging economy and efficiency and preventing fraud, waste and mismanagement. We also monitor legal issues that have a broad effect on the Inspector General community and present testimony and other communications to Congress as appropriate.

FEHBP Inclusion Under HIPAA a Necessity

During the current reporting period, we have continued exercising our oversight responsibilities regarding regulatory and legislative issues, examining in particular those having a direct effect on our Office of Inspector General mission.

With a new Congress and new Administration in place, we will be monitoring with particular interest OIG's legislative priorities held over from the 106th Congress that we hope will receive early consideration. These priorities are:

- Including the Federal Employees Health Benefits Program (FEHBP) in the Health Insurance Portability and Accountability Act (HIPAA) anti-fraud provisions.
- Amending the IG Act to improve OIG operations.
- Establishing statutory law enforcement authority for special agents in 23 presidentially appointed OIGs that do not currently have individual statutory authority.

We will also be following any new legislative proposals in the 107th Congress that may affect the IG community as a whole and our OIG operations in particular. With respect to regulatory issues, we are also hopeful that the draft administrative sanctions regulations our OIG completed last summer will be placed in the *Federal Register* for public comment and that the final regulations can be implemented later this year.

More details about the importance of this administrative sanctions program to our office and our agency can be found under Administrative Sanctions Activities in this section on pages 3-4.

Legislative Review

As we begin the first session of the 107th Congress, we consider the subjects of the three articles appearing in this section to be of utmost importance for legislative consideration and passage in this Congress.

FEHBP Inclusion in HIPAA Anti-Fraud Provisions

Since 1996, our OIG has considered its foremost legislative priority to be passage of legislation to rectify the statutory exclusion of the Federal Employees Health Insurance Program (FEHBP) from the anti-fraud enforcement provisions of the Health Insurance Portability and Accountability Act of 1996.

Health care fraud is as important an issue in the FEHBP as it is in all other federal health care programs. Unfortunately, our agency does not have the

IG Community Supports IG Act Amendments

same enforcement tools or sanction authorities provided to other agencies for the simple reason that the FEHBP has never been included under HIPAA's anti-fraud provisions. The latter led U.S. Attorney's offices in a number of cases to process our FEHBP health care fraud cases differently from those involving the same type of offenses existing in other federal health care programs. This gets particularly complicated when cases of fraud reveal Medicare violations as well as FEHBP violations. In those instances, the FEHBP's exclusion from HIPAA coverage means that the FEHBP portion of these cases often must be negotiated and settled separately. In some situations, this has led to significant delays in monetary recoveries for the FEHBP.

Within the context of our commitment to carry out our OIG mission against waste, fraud and abuse, our office remains strongly committed to early passage of any bill that would include the FEHBP under the provisions of the Federal Employees Health Insurance Portability and Accountability Act.

Amending the IG Act

During the 106th Congress, Chairman Susan Collins, Senate Permanent Subcommittee on Investigations, introduced the Inspector General Act Amendments of 1999 (S.870), which, among other issues, addressed the following:

- Setting IG term limits.
- Prohibiting performance and cash awards for IGs.
- Increasing pay rates for IGs.
- Providing external reviews of OIG operations.
- Changing OIG reporting requirements.

Senator Collins worked closely with several IGs in drafting many of the bill's provisions that the IG community felt must be addressed through legislation. None were more important than those referenced in the preceding bulleted items and which Inspector General McFarland supported. This was one of several pieces of legislation before the Senate Governmental Affairs Committee that did not pass before adjournment.

In early January, however, Representative Judy Biggert introduced legislation similar to S.870. This bill has been referred to the House Committee on Government Reform. Many of the provisions that Inspector General Patrick McFarland supported in S. 870 also appear in H.R. 44. We will continue to follow this legislation closely.

OIGs Seek Statutory Law Enforcement Authority

OIGs Need New Statutory Law Enforcement Authority

Over the years, it has been demonstrated repeatedly that there is an ongoing need within the IG community to have law enforcement authority to exercise its investigative mandate under the IG Act. While the IG Act authorizes the Inspector General community to investigate fraud and other types of wrongdoing in federal programs, it is totally silent on the subject of having authority to make arrests, carry firearms, serve warrants, and perform other associated activities.

As a result of this exclusion—and prior to 1995—OIG special agents conducting criminal investigations were required to ask the Department of Justice (DOJ) for deputation from the U.S. Marshals Service on a case-by-case basis to exercise law enforcement powers to investigate fraud and abuse within their respective agency programs. However, by 1995, the DOJ and the IG community had agreed that this special U.S. Marshals deputation process, using a case-by-case approach, was cumbersome, time consuming and inflexible. The workload of

the IG community by then had evolved to the point that a more practical approach was necessary.

To help resolve the problem and relieve this administrative burden for OIGs—as well as the U.S. Marshals Service—the Department of Justice agreed to provide blanket deputation to over 2,600 special agents, designating them Special Deputy U.S. Marshals. These special agents were from 23 specific OIGs, each headed by a presidentially appointed Inspector General, with none having independent law enforcement authority.

The frequency with which these law enforcement authorities have been exercised by OIG special agents is reflected in recent OIG statistics. For example, during fiscal years 1998 and 1999, special agents covered by blanket deputation made 1,294 arrests and served 694 arrest and search warrants. OIG special agents coordinate their efforts with the DOJ and other law enforcement agencies while also participating on numerous task forces.

Deputations have proven useful as an interim measure. However, the one major drawback of the blanket deputation approach remains: it must be renewed periodically, thus continuing the administrative burden for OIGs and the U.S. Marshals Service. And so, during the 106th Congress, the IG community opened discussions with congressional leaders to explore the possibility of providing this type of law enforcement authority permanently via statute. We, of course, strongly support these efforts since the statute would give criminal investigators from this office and the other 22 OIGs similarly affected the same authorities to conduct the business of our statutorily mandated investigations as other federal criminal investigation offices outside the IG community.

Administrative Sanctions Activities

Background. As we have discussed on a continuing basis in our semiannual reports, OPM and our OIG have been working for several years to implement administrative sanctions of health care providers. These sanctions address their improper or wrongful conduct that threatens the interests of the FEHBP or its subscribers.

Administrative sanctions, including debarments, suspensions and civil monetary penalties, can be imposed directly by an agency, and, if structured properly, can be a highly effective means of enforcing integrity in federal programs. Virtually every federal agency has some form of administrative sanctions program in place. Most notable in the health care area is the exclusion (i.e., debarment) program for Medicare providers that the OIG of the Department of Health and Human Services has conducted successfully for nearly 15 years.

Administrative sanctions authority for FEHBP providers was contained in legislation that amended the FEHB law in 1988. However, the procedures called for were far more stringent than those of any other federal sanctions program, rendering the sanctions ineffective and cost-prohibitive to operate. Especially problematic was the provision that no sanctions order could become effective until all avenues of appeal—both administrative and judicial— had been exhausted. This virtually invited prolonged litigation and the associated delay and expense.

In 1991, the U.S. General Accounting Office identified the absence of effective sanctions authorities as a significant weakness in OPM's ability to protect the FEHBP against fraud, waste and abuse.

OIG Issues 2,116 "Common Rule" Sanctions During Reporting Period

Administrative Sanctions Regulations to be Resubmitted

Common rule administrative sanctions. As an interim response to the deficiencies of the FEHBP sanctions authorities provided in the 1988 amendments to the FEHB law, OPM later joined a government-wide regulatory system that provided an efficient but limited debarment authority. This regulatory system, known as the nonprocurement debarment and suspension common rule, permits debarment actions taken by one agency against providers to be applied directly by other agencies.

Since 1993, our office has used these common rule regulations to implement within the FEHBP debarments of health care providers by other federal agencies. These regulations do not, however, offer the specialized focus tailored to health care issues that is needed to support a fully effective FEHBP sanctions program, nor do they provide a means to recover FEHBP funds that have been paid to providers as a consequence of their misconduct.

During the current reporting period, we issued 2,114 common rule debarments. This represents the highest total for any reporting period in our eight years of common rule activities. In response to an especially egregious case, we were also able to use the common rule to suspend a provider (and his associated medical clinic) who had been indicted on 59 counts of health care fraud and related violations, many of them directly involving FEHBP enrollees. Our OIG special agents conducted this investigation with the assistance of the FBI. For further details concerning this case, please refer to page 33 of this report.

Legislative remedy enacted. Ten years after the original – but flawed – administrative sanctions provision was enacted, Congress responded to our repeated efforts to secure a revised and effective sanctions authority by enacting the Federal Employees Health Care Protection Act of 1998. This legislation became P.L. 105-266 on October 19, 1998, and contained administrative sanctions provisions, including debarment, suspension and civil monetary penalties, designed specifically to safeguard the FEHBP and its enrollees from untrustworthy health care providers. Its procedures offer a sound basis for timely and cost-effective administration of the sanctions authorities.

Drafting and implementing sanctions regulations. With passage of P.L. 105-266, our office began drafting administrative sanctions regulations in early 1999. After careful and deliberative work on these proposed regulations, we presented them to former OPM Director Lachance last summer for her review. As we reported in our semiannual report last fall, Director Lachance approved them and forwarded them to the Office of Management and Budget (OMB) in August 2000.

This regulatory package was not published in the *Federal Register* prior to the presidential transition in January 2001. Therefore, in accordance with the new Administration's directive regarding pending and uncompleted regulatory actions, these proposed sanctions regulations have been returned to OPM for resubmission to OMB by the new OPM Director once this individual is confirmed. OPM management has indicated that issuance of the proposed sanctions regulations will be one of its highest regulatory priorities for 2001.

Audit Activities

Health and Life Insurance Carrier Audits

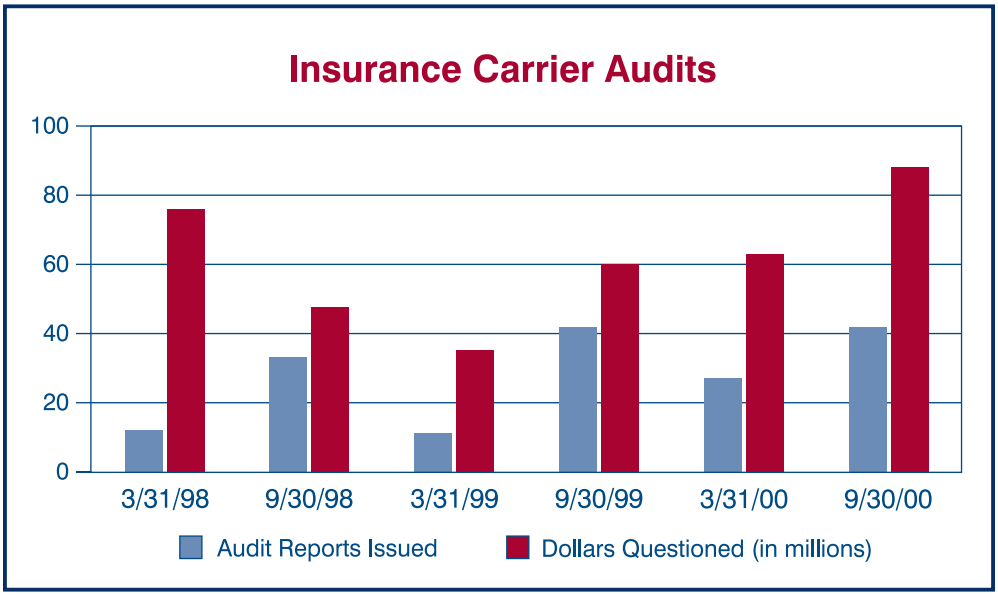
The Office of Personnel Management (OPM) contracts with private-sector firms to underwrite and provide health and life insurance benefits to federal employees, annuitants, and their dependents and survivors through the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). Our office is responsible for auditing these benefits program activities.

Our audit universe contains approximately 365 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations, as well as two life insurance carriers. These groups shared in annual premium payments in excess of $19 billion.

During the current reporting period, we issued 36 final reports on organizations participating in the FEHBP, 30 of which contain recommendations for monetary adjustment in the aggregate amount of $214.3 million due the FEHBP. A complete listing of all these reports is provided in Appendices III and V on pages 42-44 and page 45, respectively, of this report.

We believe it is important to illustrate the dollar significance resulting from our audits of FEHBP carriers and what this means to the FEHBP trust fund. For instance, during the past six semiannual reporting periods, the OIG issued 167 reports and questioned $368.9 million in inappropriate FEHBP charges as the graph below illustrates.

The sections that immediately follow explain the differences among the types of FEHBP carriers and provide audit summaries of significant final reports we issued during the past six months.



Community-Rated Plans

Our office is responsible for auditing community-rated and experienced-rated health plans. Within the first category are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). Our community-rated HMO audit universe covers approximately 265 rating areas. A community-rated carrier generally sets the subscription rates based on the average revenue needed to provide health benefits to each member of a group, i.e., private companies, state or county entities, the FEHBP, etc.

Under current statutes, HMO subscription rates can vary from group to group. The rates derive from two predominant rating methodologies. The key rating factors for the first methodology (*community rating by class)* are the age and sex distribution of a group's enrollees. In contrast, the second methodology (*adjusted community rating)* is based on the projected use of benefits by a group using actual claims experience from a prior period of time adjusted for increases in medical cost. However, once a rate is set, it may not be adjusted to actual costs incurred. The inability to adjust to actual costs, including administrative expenses, distinguishes community-rated plans from experience-rated plans. The latter category includes experienced-rated HMOs and fee-for-service plans.

For the period 1991 through 1994, the applicable regulations for HMOs required that subscription rates charged to the FEHBP be equivalent to the rates charged the two subscriber groups closest in size (*actual number of enrollees*) to the FEHBP and whose respective contracts and contain similar benefits. In 1995, the provision requiring similar benefits was eliminated. Under these revised regulations, each carrier must certify that the FEHBP is being offered rates equivalent to the rates given to the two groups closest in size to the FEHBP. It does this by submitting to OPM a certificate of accurate pricing. These rates are determined by the FEHBP-participating carrier, which is responsible for selecting the appropriate groups. Should our auditors determine that equivalent rates were not applied to the FEHBP, a condition of defective pricing (DP) exists. The FEHBP is entitled to a downward rate adjustment to compensate for any overcharges resulting from DP.

We issued 18 audit reports on community-rated plans during this reporting period. In these reports, our auditors recommended that OPM's contracting officer require the plans to return over $120 million to the FEHBP. Below is a summary of two of these reports that illustrate typical problems encountered in conducting HMO audits.

Aetna U.S. Healthcare – New York

in Blue Bell, Pennsylvania

Report No. 1C-JC-00-00-002
February 26, 2001

Aetna U.S. Healthcare – New York has participated in the FEHBP as a community-rated comprehensive medical plan since 1986. The plan provides primary health care services to its members throughout the New York City area.

The audit covered contract years 1996, 1997 and 1999, during which time the plan received approximately $197 million in premium payments from the FEHBP. In a previous reporting period, we issued a final report resulting from a

separate audit for contract year 1998 wherein we had monetary findings of $315,926 in savings to the FEHBP.

During this current audit, we identified $13,439,139 in questioned costs, including $10,790,653 for improper health benefit charges and $2,648,486 for lost investment income. Lost investment income represents the amount of interest the FEHBP would have earned on money the plan overcharged the FEHBP had the overcharges not occurred.

Premium Rates

A key objective of this audit was to determine if Aetna U.S. Healthcare – New York met its contract requirement to offer the FEHBP the same premium rate discounts it offered to two other groups comparable in subscriber size to the FEHBP. Another was to examine specific health benefit premium charges that were not part of the plan's basic benefits package to see whether these charges were fair and reasonable to the FEHBP. These particular charges are known as "*loadings*." Finally, we looked at whether the rates were in compliance with the laws and regulations governing the FEHBP. The audit findings discussed in this report are summarized below.

Discounted market rates. The audit showed that the FEHBP did not receive a market price adjustment equivalent to the largest discount given to one of the two groups closest in size to the FEHBP in either 1996 or 1997. In both years, one of the groups selected by the plan did not meet the selection criteria set forth in the FEHBP regulations. We determined that a group other than the one the plan chose was actually closer in size to the FEHBP. Our analysis of the latter group's rates showed that it had received discounts much larger than the plan gave the FEHBP in both years.

In 1996, the group that should have been selected received a 7.2 percent discount, while the FEHBP's discount was only .04 percent. We applied the difference in the discounts to the FEHBP rates and found that the FEHBP had been overcharged $4,120,200. The plan does not agree with the subscriber group we selected in lieu of the one it chose. The plan stated that both subscriber groups it identified were appropriate and that no FEHBP overcharges occurred in 1996.

In 1997, the group that we designated in place of the plan's choice received a 10.3 percent discount. Since the FEHBP did not receive a discount of any kind, we applied the full 10.3 percent to the FEHBP rates. As a result, our auditors determined that the FEHBP was overcharged $6,516,020. The plan agreed that the FEHBP is due a price adjustment for 1997, but not $6,516,020. The plan contends that the FEHBP is only due $1,679,489, basing its calculations on the discount it gave to one of the groups it selected over the one our auditors identified as the correct one. We strongly disagreed with the plan's position and recommended in our audit report that OPM's contracting officer require the plan to return $6,516,020 to the FEHBP.

Substance abuse loading. We also found that the plan incorrectly calculated the substance abuse loading in contract years 1997 and 1999. As mentioned earlier, a *loading* is a health benefits charge that is in addition to the charge for the plan's basic health benefits package. Based on our auditors' calculations, overcharges amounted to $71,556 in 1997 and $82,877 in 1999, for a total of $154,433. The plan agreed to return this amount to the FEHBP.

Auditors Identify $13.4 Million in Questioned Costs to FEHBP

Auditors Determine FEHBP Due $11.1 Million

Lost Investment Income

The FEHBP contract with community-rated carriers states that the FEHBP is entitled to the recovery of lost investment income on defective pricing findings. We determined that the FEHBP is due $2,648,4860 from the plan for lost investment income through December 31, 2000, on the overcharges identified in the report. An additional amount is also due from the plan for the period beginning January 1, 2001, until all funds have been returned to the FEHBP.

United Healthcare Select

in Minneapolis, Minnesota

Report No. 1C-H8-00-00-010
December 8, 2000

United Healthcare Select (United) entered the FEHBP in 1987 as a community-rated comprehensive medical plan. Although its headquarters are located in Minnesota, the plan provides health care services to members in the St. Louis metropolitan area as well as mid- and southern Missouri. The audit covered contract years 1994 through 1999. During this six-year period, the plan received over $122 million in premiums from the FEHBP.

Our auditors identified $9,190,865 in inappropriate charges to the FEHBP in contract years 1994, 1995, 1997, and 1998. In addition, the FEHBP is due $1,939,275 for investment income lost as a result of the overcharges. The plan agrees that the FEHBP was overcharged, but believes the overcharge is less than our auditors calculated.

Premium Rates

The primary objectives of the audit were to determine if United Healthcare Select gave the FEHBP the same premium rate discounts it gave to similarly sized groups that met the selection criteria under its FEHBP contract and if any additional health benefit charges (*loadings*) the FEHBP received were fair and reasonable. We also looked at whether the rates were in compliance with the laws and regulations governing the FEHBP. All our findings relate to defective pricing that occurred because the plan did not give the FEHBP the correct premium rate discounts.

Discounted rates. We found that in only two of the six contract years (1996 and 1999) we reviewed did the FEHBP receive a market price adjustment equivalent to the largest discount given to the two groups closest in size to the FEHBP as called for under its contract.

In the other four years (1994, 1995, 1997, and 1998), the FEHBP either did not receive equivalent discount rates (1994, 1995 and 1997) or received none (1998). In the former, United selected a subscriber group in these years not comparable in size to the FEHBP. Specifically, the groups the plan should have selected received discounts of 13.27 percent, 14.4 percent, and 20 percent, respectively. While the FEHBP received discounts in these years, the discounts were not as large as those given to these groups.

Since the plan incorrectly selected other plans as closest in subscriber size to the FEHBP, it violated a contract requirement. After applying the appropriate discounts to the FEHBP rates, we determined that the FEHBP was overcharged $1,979,586 in 1994; $1,893,611 in

1995 and $3,674,689 in 1997, totaling $7,547,886 overall.

In 1998, the group that the plan correctly selected received the highest discount (7.3 percent). Since the FEHBP did not receive a discount of any kind from the plan, we applied the 7.3 percent discount to the FEHBP rates and found that the FEHBP was overcharged $1,642,799.

Lost Investment Income

Consistent with the FEHBP contract with community-rated carriers, the FEHBP is entitled to lost investment income on all defective pricing findings. We determined that the FEHBP is due $1,939,275 for lost investment income covering the years 1994 through 1999. In addition to this amount, we recommended that OPM's contracting officer charge the plan lost investment income on amounts due for the period beginning January 1, 2000, until all funds have been returned to the FEHBP.

Experienced-Rated Plans

In addition to community-rated, comprehensive medical plans, (refer to page 6 for a discussion of HMOs), the Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, that constitute the majority of federal contracts in this category. There are also certain comprehensive medical plans that qualify as experience-rated HMOs.

An experience rate is a rate that reflects a given group's projected paid claims, administrative expenses and service charges for administering the FEHBP contract. Each carrier maintains separate accounts for its federal contract, and future premiums are adjusted to reflect the federal enrollees' actual past use of benefits. The universe of experience-rated plans currently consists of about 100 audit sites. The number of audit sites fluctuates due to contracts not being renewed or because of plan mergers and acquisitions.

When auditing these plans, our auditors generally focus on three key areas:

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

During this reporting period, we issued 17 audit reports on experience-rated plans, one of which was an HMO comprehensive medical plan. In these reports, our auditors recommended that OPM's contracting officer require the plans to return $93.9 million to the FEHBP.

Government-Wide Service Benefit Plan

This plan comes under the broad definition of a fee-for-service plan and is administered by the BlueCross and BlueShield Association (BCBS Association), which contracts with our agency on behalf of its member plans. Participating Blue Cross and Blue Shield plans throughout the United States underwrite and process the health benefits claims of their federal subscribers under the BCBS Service Benefit Plan. Approximately 46 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans nationwide.

While its headquarters are in Chicago, Illinois, for administrative purposes, the BCBS Association has established a Federal Employee Program (FEP)

Lost Investment Income Exceeds $1.9 Million

Auditors Calculate $5,996,561 Owed to the FEHBP

Director's Office in Washington, D.C., to provide centralized management for the Service Benefit Plan. The Association oversees a national FEP operations center, also located in the Washington, D.C. area, whose activities include verifying subscriber eligibility; approving or disapproving reimbursement of local plan FEHBP claims payments (using computerized system edits); and maintaining an FEHBP claims history file and an accounting of all FEHBP funds.

During this reporting period, we issued 15 BlueCross and BlueShield experience-rated reports in which our auditors cited $65.8 million in costs charged to the FEHBP that were determined unallowable under BCBS contracts. Our auditors also noted an additional $24.6 in lost investment income on these questioned costs, for a total of $90.4 million owed to the FEHBP. The following audit narrative describes the major findings from one of these reports as well as the questioned costs associated with them.

CareFirst BlueCross BlueShield

in Owings Mills, Maryland

Report No. 1A-10-06-99-055
November 13, 2000

Our audit of the FEHBP operations at CareFirst BlueCross BlueShield (CareFirst) took place at the plan's headquarters in Owings Mills, Maryland. We reviewed health benefit payments made by the plan from July 1, 1995 through June 30, 1999, as well as administrative expenses and miscellaneous payments covering contract years 1993-1998.

In performing this audit, we determined whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. As a result, our auditors questioned $4,783,026 in claim payments; $1,050,772 in administrative expenses; and $51,308 in refunds. Of these amounts, the BCBS Association agreed with $4,384,336 and disagreed with $1,449,462. Lost investment income on these questioned costs totaled $162,763. Final calculations by our auditors regarding all inappropriate charges and lost investment income to the FEHBP totaled $5,996,561.

Health Benefits

During the period July 1, 1995 through June 30, 1999, the plan made $843 million in actual FEHBP claim payments. We selected claims at random as well as in specific health benefit categories, principally those concerning coordination of benefits with Medicare and potential duplicate payments. We also reviewed specific financial and accounting areas, such as refunds and other miscellaneous credits relating to FEHBP claim payments. Our findings relating to health benefit charges totaled $4,783,026. Some of our findings in these areas were:

Coordination of benefits. Although we have identified coordination of benefits (COB) problems during our audits at many other plans, we were surprised by the magnitude of this problem at CareFirst. We identified 11,080 claim lines where the FEHBP paid as primary insurer when Medicare was actually the primary insurer. We estimated that these claim payment errors cost the FEHBP $4,418,596.

CareFirst's explanation for this COB oversight was that no information existed in the FEP national claims system database maintained at the FEP operations center to make the plan aware that this coordination was necessary.

However, when this Medicare information was later added to the FEP claims system, CareFirst still failed to review and adjust the members' prior claim lines back to the Medicare effective dates. Therefore, the claims benefit charges remained charged to the FEHBP in their entirety. These claims had to do with Medicare Parts A and B. Similarly, CareFirst did not follow its procedures and coordinate inpatient claims when patients had Medicare Part B only. We have recommended that OPM's contracting officer disallow these uncoordinated claim payments and instruct CareFirst to make a diligent effort to recover these overpayments and credit all amounts recovered to the FEHBP.

Medicare Part A helps pay for care in hospitals, skilled nursing facilities, hospices, and some home health care.

Medicare Part B helps pay for doctors, outpatient hospital care, and some other medical services that Part A does not cover, such as services of physical and occupational therapists and some home health services.

Duplicate claim payments. Our auditors also determined that CareFirst inappropriately charged the FEHBP for duplicate claim payments during the period covered by this audit. Of the approximately $843 million in claims paid during this period, we identified 428 duplicate claim payments, totaling $301,637. However, we concluded that this relatively small number of duplicate claim payments indicated that CareFirst had effective controls in place to minimize such payments.

Recoveries and refunds. CareFirst did not provide documentation to substantiate that five fraud recoveries and one health benefit refund ($41,768 and $7,155, respectively), had been credited to the FEHBP. The FEHBP contract requires the carrier to retain and make available all records applicable to a contract year that support the annual statement of operations. As a result, we recommended that the contracting officer ensure that the plan credits the FEHBP for these recoveries.

Administrative Expenses

During our review of administrative expenses from 1993-1998, we noted that CareFirst charged the FEHBP for unallowable and unsupported costs totaling $1,111,489, the bulk of which related to unallowable subcontract costs. We also noted that the plan undercharged the FEHBP $60,717 for pension costs it was entitled to receive from the FEHBP. Under the terms of its FEHBP contract, CareFirst can charge personnel expenses, including salary and pension costs, as administrative expenses for work associated with the contract.

Unallowable subcontract costs. CareFirst charged the FEHBP for two subcontracts that were not approved by OPM's contracting officer. Federal regulations specifically state that the plan must notify and receive approval from the contracting officer in advance of entering into a subcontract or subcontract modification if: (1) the amount of the subcontract exceeds $100,000; and (2) the amount is at least 25 percent of the total cost of the subcontract. In each instance, the contracting officer denied the plan's request for approval.

Since OPM's contracting officer did not approve these two subcontracts, we determined that the FEHBP is due $1,085,941 for costs associated with these subcontracts.

Inappropriate Health Benefit Charges Total $4,783,026

Plan Charges the FEHBP $1,085,941 in Costs for Denied Subcontracts

Experienced-Rated Comprehensive Medical Plans

As explained earlier in this section, comprehensive medical plans fall into either the community-rated or experience-rated category and are commonly referred to as health maintenance organizations (HMOs). The critical difference between the two categories stems from how premium rates are calculated for each (see page 6).

Like other health insurance plans participating in the FEHBP, experienced-rated HMOs offer what is termed a "point of service" product. Under this option, members have the choice of using a designated network of providers or using non-network providers at additional costs. In selecting one health provider over another (the point of service), a member's choice has specific monetary and medical implications. For example, if a member chooses a non-network provider, the member will pay a substantial portion of the charges and the benefits available may be less comprehensive.

As mentioned previously, we issued one comprehensive medical plan audit report during this reporting period. The following audit narrative describes the major findings from this report, along with questioned costs associated with those findings.

Hawaii Medical Service Association

in Honolulu, Hawaii

Report No. 1D-87-00-00-030
January 31, 2001

Hawaii Medical Service Association (HMSA) is a comprehensive medical plan, located in Honolulu, Hawaii, providing health benefits to approximately 27,000 federal enrollees and their families in Hawaii. In addition to offering comprehensive health services and benefits for accidents, illness and injury, HMSA places emphasis on preventive benefits, such as office visits, physical examinations, immunizations and well-child care.

The purpose of this audit, which covered contract years 1995-1999, was to determine whether HMSA charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract. Our auditors examined health benefit payments made by HMSA from 1997 through 1999, as well as miscellaneous adjustments, administrative expenses and cash management processes.

At the conclusion of this audit, our auditors determined that HMSA improperly charged the FEHBP $736,856 in claim payments and never credited the FEHBP $15,569 for a refund. Final calculations by our auditors regarding amounts owed the FEHBP totaled $752,425. HMSA agreed with all the questioned amounts.

Health Benefits

During the period 1997 through 1999, HMSA paid $300 million in actual claim payments. We selected claims at random, as well as in specific health benefits categories, principally those concerning coordination of benefits with Medicare and duplicate payments. We also reviewed FEHBP claim payments activities relating to refunds and uncashed checks. Our findings related to health benefit charges totaled $752,425. The findings in these areas are highlighted below.

Coordination of benefits. For the period 1997-1999, our auditors identified 35 inpatient claim overpayments, totaling $763,362, where the FEHBP paid as the

primary insurer when Medicare Part A or B was the primary insurer. This type of inappropriate charge occurs when there is a failure to coordinate benefits properly with Medicare coverage. We recommended that OPM's contracting officer disallow these uncoordinated claim payments, and instruct HMSA to make a diligent effort to collect these payments and credit all amounts recovered to the FEHBP.

Duplicate payments. Our auditors also determined that HMSA charged the FEHBP inappropriately for duplicate claim payments. During the review period of 1997-1999, we identified 14 duplicate claim payments, resulting in overcharges of $21,055 to the FEHBP. This relatively small number of duplicate claim payments indicated to our auditors that HMSA had effective controls in place to minimize payments of this type. Nevertheless, we recommended that OPM's contracting officer disallow the duplicate payments, instructing HMSA to be conscientious in trying to collect these payments and credit all amounts recovered to the FEHBP.

Claim payment errors. For the period January 1, 1999 through December 31, 1999, we selected 80 claims and determined if HMSA paid these claims properly. As a result of this review, our auditors identified four claim payment errors, resulting in overcharges of $40,298 to the FEHBP. We also identified 11 additional claim payment errors during our coordination of benefits review that showed that the plan undercharged the FEHBP $87,859.

Our auditors determined that undercharges exceeded overcharges to the FEHBP for the above 15 claim payment errors, for a net of $47,561 in undercharges. In recommending that OPM's contracting officer direct HMSA to make a diligent effort to collect the claim overpayments and credit all amounts recovered to the FEHBP, our auditors also recommended that OPM's contracting officer allow HMSA to charge the FEHBP for the claim undercharges if additional payments are made to the providers to correct the underpayment errors.

Under its FEHBP contract, should HMSA be able to demonstrate that all forms of claim overpayments cited in our audit report were made in good faith and can show further that it made a reasonable effort to collect these funds, then OPM's contracting officer can consider all uncollected amounts (i.e., questioned costs by our auditors) to be allowable charges to the FEHBP. This applies to all FEHBP Blue Cross and Blue Shield plan contracts.

Miscellaneous adjustments. In reviewing HMSA's procedures for handling FEHBP refunds and uncashed health benefit checks, we identified one instance where HMSA did not credit the FEHBP $15,569 for a refund.

Administrative Expenses

During our review of administrative expenses from 1995-1999, we noted that HMSA allocated unallowable advertising, public relations, and lobbying expenses of $1,383,217 to the FEHBP. Federal regulations specifically state that lobbying expenses are unallowable. Regarding advertising and public relation expenses, federal regulations generally state that such costs are unallowable. For the same period, however we noted that $7,321,836 in administrative expenses were not reimbursed to HMSA since it had exceeded the contract limitation set for administrative expenses reimbursement. Our auditors, therefore, did not recommend any monetary adjustments for this finding.

Auditors Determine $752,425 Owed to the FEHBP

Plan Agrees With $2,676,415 in Audit Findings

Employee Organization Plans

Employee organization plans also fall into the category of experience-rated and may operate or sponsor participating health benefits programs.

The two largest types of employee organizations are federal employee unions and associations. Some examples are the American Postal Workers Union, the National Association of Letter Carriers, the Government Employees Hospital Association and the Special Agents Mutual Benefit Association. These plans operate on a fee-for-service basis, which allows members to obtain treatment through facilities or providers of their choice.

During the reporting period, we issued one employee organization plan audit report relating to the Mail Handlers Benefit Plan (MHBP) (***Report No. 1D-87-00-00-030***). Specifically, we examined the FEHBP operations at the plan's administrator, Claims Administration Corporation (CAC), based in Rockville, Maryland. CAC processes FEHBP claims on behalf of Continental Assurance Company, which underwrites this plan.

The audit covered contract years 1997-1999, and was conducted to determine whether costs were charged appropriately under the terms of MHBP's FEHBP contract.

As a result of the audit, our auditors questioned $1,851,747 for duplicate claim payments, $709,889 for uncoordinated claim payments with Medicare (see page 12 for COB issue addressed in previous audit narrative), and other claim payment errors for $114,779. In total, our auditors questioned $2,676,415 for inappropriately charged FEHBP claim payments covering the contract years we examined. CAC agreed with all questioned costs.

Information Systems Audits

In accordance with the Inspector General Act of 1978, as amended, we conduct and supervise independent and objective audits of agency programs and operations to prevent and detect fraud, waste and abuse. To assist in fulfilling this mission, we perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program (FEHBP) and the Federal Employees' Group Life Insurance program (FEGLI). We also audit the agency's computer systems development and management activities.

Our information systems audit group, while relatively new, continues to gain experience through audits of health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP) as well as through its reviews of OPM computer systems security activity. Thus far, the results are encouraging.

The inherent need for this type of oversight lies in the reality that the federal government is heavily reliant on information systems to administer federal programs, manage federal resources, and accurately report costs and benefits. Any breakdown in federal computer systems, including systems of federal contractors, can compromise the government's efficiency and effectiveness and increase the costs of federal projects and programs. The importance of this issue is also underscored by the increasing frequency of malicious threats to government computer systems, outbreaks of destructive computer viruses, Web site defacements, and theft of valuable or sensitive information in computer databases.

To counter this threatening climate, our office audits various agency computer systems development and security-related activities. In addition, our office audits general and applications controls at health carriers under contract with OPM to provide health benefits under the FEHBP. *General controls* are defined as 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.

During this reporting period, we completed a review of OPM's efforts to protect the critical infrastructure of its computer-based systems. We also completed one external audit of general computer controls at an FEHBP health carrier. A summary of our audit findings and recommendations, as well as customer response to both, follows.

Audit of General Information System Controls American Postal Workers Union Health Plan

in Silver Spring, Maryland

Report No. 1B-47-00-00-027
January 2, 2001

The American Postal Workers Union Health Plan (APWU), in Silver Spring, Maryland, has received approximately

APWU Agrees with OIG Computer Security Recommendations

$400 million in FEHBP program income associated with its FEHBP contract. Our auditors conducted this particular audit, which covers contract year 1999, to obtain reasonable assurance that APWU had implemented proper controls over the integrity, confidentiality and availability of computerized data associated with its FEHBP contract operations.

We evaluated the plan's internal control structure, specifically its general information system controls, using industry standards, guidance contained in the General Accounting Office's *Federal Information System Controls Audit Manual*, along with pertinent federal law and regulations.

This review included examining how well the company was managing security policy and access controls, along with software changes related to its general information systems. Our auditors also assessed whether there was an appropriate segregation of duties among APWU employees who were involved in the plan's general information systems. For example, we wanted to make sure that, where necessary, different individuals were involved at critical steps of a given process rather than the same people having access to each of these steps. Additionally, we looked at controls over the mainframe operating system and examined the company's plan for keeping the totality of its computer systems running after a disaster, natural or otherwise.

Our audit revealed several areas where APWU could improve its computer-related general control structure. These areas are: developing a comprehensive security plan; tightening access controls; improving software development and change controls; implementing a disaster recovery plan; and strengthening controls over the mainframe operating system.

Our auditors made a number of recommendations to address these internal control weaknesses. As a result, APWU agreed to:

- Publish a corporate security policy.
- Introduce a security awareness training program.
- Improve security-related personnel controls.
- Tighten access controls on its mainframe computer.
- Establish policy regarding software change management.
- Formally document its disaster recovery program.
- Enhance the integrity of its mainframe operating system.

We believe that our review of information system general controls at APWU, along with our specific recommendations, will serve the dual purpose of protecting the private medical records of federal employees enrolled in this health plan and preventing any potential fraud, waste and abuse in the FEHBP.

Review of OPM's Compliance with Presidential Decision Directive 63

Report No. 4A-OP-00-00-075
December 15, 2000

We conducted a review of OPM's compliance with Presidential Decision Directive 63 (PDD 63), dated May 1998. This directive requires that each department and agency of the federal government be responsible for protecting its own critical infrastructure.

IG Community Provides Support for PDD 63 Agency Infrastructure Assurance Program Initiative

As defined in PDD 63, critical infrastructures are systems so vital that their incapacity or destruction would have a debilitating impact on national defense or economic security. Within the context of our agency's operations, we believe that OPM's retirement, health insurance, and life insurance programs are examples of such critical infrastructures.

Advances in information technology have caused computer-based infrastructures to become increasingly automated and interlinked, and have created new vulnerabilities due to equipment failures, human error, weather, along with physical and cyber attacks. Cyber attacks, of course, come primarily through the Internet. To combat these increased vulnerabilities, PDD 63 requires each agency to:

- Appoint an individual (Chief Information Assurance Officer) to lead its efforts in identifying and protecting an agency's critical infrastructure.
- Develop a plan for protecting an agency's critical infrastructure.
- Cooperate with a national infrastructure protection center that will serve as the national focal point for threat assessment, warning, investigation, and response to attacks on critical infrastructures.
- Develop controls to restrict its computer systems access to only authorized individuals.

  Note: Access controls would include physical access restrictions, as well as "logical" access restrictions, such as passwords.
- Work with the Office of Management and Budget to include assigned infrastructure assurance functions within its Government Performance and Results Act strategic planning and performance measurement framework.

In the fall of 1999, the President's Council on Integrity and Efficiency (PCIE) and the Executive Council on Integrity and Efficiency (ECIE) agreed that the Inspector General community could provide support for the President's directive by initiating a government-wide review of agency infrastructure assurance programs. The review would consist of four phases. Phases I and II relate to critical ***computer-based*** infrastructures, while Phases III and IV relate to critical ***physical*** infrastructures.

In order to complete the reviews in a consistent manner, a PCIE/ECIE working group was established. The working group, chaired by the OIG at the National Aeronautics and Space Administration, has the overall responsibility to:

- Develop review guides.
- Coordinate the efforts of the participating Offices of Inspector General.
- Prepare and issue consolidated reports summarizing the results of the reviews.
- Make government-wide recommendations as appropriate.
- Conduct follow-up work regarding recommendations.

In turn, the participating OIGs are responsible for conducting reviews at their respective agencies and reporting the results to the working group.

In accordance with Phase I of this multi-agency assessment, we evaluated the adequacy of OPM's planning and assessment activities for protecting its critical computer-based infrastructure. Specifically, this included a review of OPM's critical infrastructure protection plan, asset identification efforts, and vulnerability assessments as appropriate.

Our Phase I review shows that OPM management officials have a strong commitment to protecting the agency's

OIG Recommends OPM Officials Formally Implement PDD 63

critical assets. The agency has devoted significant efforts to improving the overall security of OPM's information systems. However, we have observed that OPM has not taken the action necessary to address formally those critical infrastructure planning and assessment requirements defined in PDD 63. We believe that the computer security control efforts that have been introduced and planned can be used as a basis to meet the directive's requirements.

Agency officials believe that PDD 63 requirements should be addressed using security best practices criteria instead of requiring strict implementation. They also indicated that a lack of adequate funding limits OPM's ability to implement this presidential directive.

Our office's position is straightforward: We believe that PDD 63 applies to OPM and that it is in OPM's best interest to comply with it as a structured strategy to minimize the risks associated with cyber attacks. Certainly, recent events, including the Melissa and I Love You virus attacks on computer hard drives and files, have highlighted an increased risk for all computer systems to cyber attack.

As we indicated above, OPM has taken information technology security very seriously. For example, we have noted steps OPM management has taken to enhance, update and consolidate OPM's information technology security policies. Agency management has also refocused and increased resource commitments to this highly visible issue.

While we agree that these steps provide improved protection for OPM's critical infrastructure, we also continue to believe that formally implementing PDD 63 will enhance our agency's efforts to protect its critical computer-based infrastructure. This has led us to recommend to OPM management that it take the action necessary to implement PDD 63.

Our office has now completed its Phase I review and forwarded those results and recommendations to the IG community's President's Council on Integrity and Efficiency and Executive Council on Integrity and Efficiency. The PCIE/ECIE consolidated Phase I report to the Office of Management and Budget can be reviewed on the IGNet Web site at *http://www.ignet.gov/randp/rpts.html#2001*.

As the above audit work illustrates, in today's computer-dependent work environment, it is essential that we take the position that security measures are of paramount importance in protecting sensitive data and ensuring that federal funds are safeguarded. To this end, we recognize the significant role our information systems audits group can play by helping the FEHBP health insurance carriers assess their security risks and make improvements where necessary.

Likewise, regarding our oversight of OPM's internal computer systems and operations, our auditors believe that monitoring the work performed by independent external auditors provides additional assurance that our agency's computer-based operations will remain secure.

Other External Audits

When requested by Office of Personnel Management (OPM) procurement officials, our office conducts pre- and post-award contract audits relating to the acquisition of goods and services by agency program offices. We also conduct audits of the local organizations of the Combined Federal Campaign (CFC), the only authorized fund-raising drive conducted in federal installations throughout the world.

Agency Contract Audits

Our office conducts two types of agency contract audits. We perform pre-award contract audits to: (1) ensure that a bidding contractor is capable of meeting contractual requirements; (2) assess whether estimated costs are realistic and reasonable; and (3) determine if the contract complies with all applicable federal regulations. In the other instance, we conduct post-award contract audits to ensure that costs claimed to have been incurred under the terms of an existing contract are accurate and in accordance with provisions of federal contract regulations.

These audits provide OPM procurement officials with the best information available for use in contract negotiations and oversight. In the case of post-award contract audits, for example, the verification of actual costs and performance charges may be useful in negotiating future contract modifications pertaining to cost-savings and efficiency.

During this reporting period, we conducted one pre-award and one post-award contract audit at the request of OPM's Office of Contracting and Administrative Services (OCAS). The following summaries include some of the determinations we made concerning these audits.

Pre-Award Contract Audit

In August 2000, OPM management issued a request for proposals to provide consolidated facilities management services at the Federal Executive Institute (FEI) in Charlottesville, Virginia. FEI is a residential training center for advanced study and executive development.

Two potential contractors, ARAMARK Services, Inc,. and Wastren, Inc., submitted proposals to OPM's Office of Contracting and Administrative Services. ARAMARK had held the previous contract for providing consolidated facilities management services at FEI. In the following section, we discuss our post-award audit of ARAMARK and its costs charged to OPM under the expired contract. Wastren, Inc. is a multi-service corporation, located in Grand Junction, Colorado, that has significant experience in performing facility management services. OCAS requested our office audit the proposal submitted by Wastren, Inc.

Our audit determined the cost proposal submitted by Wastren, Inc., may not have been an accurate assessment of its total estimated costs required to fulfill the agency's contract requirements. We provided our report ***(No. 6A-2A-00-01-030)***,

Auditors Call for Tighter Contractor Operational Controls

to OPM's procurement officials to use in contract negotiation. Based on our audit results, OCAS awarded the contract to ARAMARK.

Post-Award Contract Audit

As we described in our semiannual report issued last fall, the subject of this post-award audit was the facilities management contractor at the Federal Executive Institute (FEI) in Charlottesville, Virginia. ARAMARK Services, Inc., provided a full range of services to FEI, including food preparation, security, and grounds maintenance, during its multiple-year contract until that contract ended December 31, 2000.

We completed the audit and issued our report ***(No. 6A-2A-00-00-070)*** on January 31, 2001. We verified actual expenses charged by ARAMARK to FEI for services performed from January 1996 through the end of calendar year 2000, and evaluated the company's compliance with the provisions in its contract and with federal regulations. We concluded that ARAMARK was in general compliance with both. However, we did note in our report that ARAMARK management was remiss in the following areas:

- Did not have written policies and procedures for determining employee eligibility for performance awards and the distribution of performance awards paid under the contract.
- Did not distribute a performance award paid under the contract to an employee who had earned the compensation, because the employee had since left the employ of ARAMARK.
- Did not properly use and make payments from the petty cash fund.
- Did not verify, in all instances, its billings to ensure only accurate and complete charges were submitted to OPM.
- Did not approve time cards or manual changes to time cards.

Combined Federal Campaign

Executive Order 10927 designated the U.S. Civil Service Commission (the precursor of OPM) as the agency responsible for arranging national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their place of employment. Since then, there have been additional executive orders, one public law (P.L. 100-202), and new federal regulations (5 CFR 950) that:

- Provide for the eligibility of national and local organizations and charities participating in the Combined Federal Campaign (CFC).
- Define the role of local CFCs.
- Cite the Office of Personnel Management's specific oversight responsibilities relating to the Combined Federal Campaign.

Since its inception on March 18, 1961, the CFC has netted over $4 billion in charitable contributions. An estimated 387 local campaigns participated in the 1999 Combined Federal Campaign, the most recent year for which statistical data is available. Federal employee contributions reached $217.8 million for the 1999 CFC, while expenses totaled $18 million.

Our CFC audits traditionally cover two consecutive campaign years and focus

on the eligibility of participating local charities, local campaign compliance with federal regulations and OPM guidelines, as well as testing financial records of the various local campaigns. This testing includes reviewing budgets, certified financial statements, general ledgers, bank statements and pledge cards to ensure that budgets, expenses, as well as cash receipts and disbursements, are accounted for correctly. Combined Federal Campaign audits will not ordinarily identify savings to the government, because the funds involved are charitable donations made by federal employees, not federal entities. While infrequent, our audit efforts can result in an internal referral to our OIG investigators for potential fraudulent activity. We reported one such case in our semiannual report issued last fall.

During the current reporting period, we issued one draft and nine final CFC reports, a listing of the latter is on page 47 in Appendix VI. We have summarized one of these reports below to illustrate results typically obtained in a CFC audit.

1998 and 1999 Combined Federal Campaigns of Southern New Jersey in Rancocas, New Jersey

Report No. 3A-CF-00-01-035
March 30, 2001

We audited the Combined Federal Campaigns for Southern New Jersey for 1998 and 1999 with the objective of determining if the administrator conducted these Combined Federal Campaigns in accordance with federal regulations and OPM's CFC guidelines.

The United Way of Burlington County served as the administrator for both campaigns. As a CFC administrator, its responsibilities included developing campaign plans and budgets, conducting pledge drives, collecting donations, and disbursing contributor donations to charities within the various localities of the southern New Jersey campaign area.

Based on our audit, we concluded that the United Way of Burlington County conducted these campaigns in accordance with federal regulations and OPM guidelines with the following notable exceptions:

- Did not distribute funds to charities in southern New Jersey in a timely manner nor on a monthly basis.
- Made one distribution to an incorrect charity.
- Charged certain unsupportable expenses in its capacity as administrator.
- Did not send notification letters to charities in a timely manner, informing them of the amounts donated to them.
- Did not submit an administrator application that met all federal regulations and OPM guidelines.
- Did not prepare the campaign brochure in accordance with federal regulations and OPM guidelines.
- Did not see that contributor pledge card data was accurately entered into its administrator data base. *(Note: In two instances, these errors resulted in erroneous distributions to charities in southern New Jersey.)*

OIG Notes Need for Stricter Adherence to CFC Regulations and Guidelines

OPM Internal Audits

Our office also has responsibility for conducting audits and evaluations and inspections of the Office of Personnel Management's (OPM) programs and administrative operations. For example, we conduct audits of OPM's consolidated financial statements required by the Chief Financial Officers Act (CFO Act); government-wide activities based on our participation in the President's Council on Integrity and Efficiency; OPM's compliance with laws and regulations, such as the Prompt Payment Act, the Federal Managers' Financial Integrity Act (FMFIA), the Federal Financial Management Improvement Act (FFMIA) and the Government Performance and Results Act of 1993 (GPRA). Further, we conduct performance audits and evaluations and inspections of OPM programs that involve the retirement, employee development, and personnel management activities.

Our internal audits staff consists of auditors and program evaluators working together to provide recommendations for improving the economy and efficiency of our agency operations. We use a risk-based methodology to assess OPM's activities and establish annual work agendas. To accomplish this, we calculate a risk rating by assigning numeric values to risk factors within the agency's program offices. The objective is to identify high impact areas where the OIG can provide the best possible benefit to the agency.

To ensure that we achieve our goals, we carefully plan, conduct and monitor our activities in accordance with government standards that apply to audits or to evaluations and inspections. We also involve OPM program managers in every step of the process to ensure that we have met their needs, addressed concerns and obtained feedback on how we can improve our auditing and evaluation activities. We believe this cooperative spirit ensures that all parties involved with our activities are satisfied with the final product.

During this reporting period, we completed three internal audits and issued final reports in the following areas: (1) OPM's financial statements; (2) agency compliance with the Government Performance and Results Act (GPRA); and (3) agency compliance with the Federal Managers' Financial Integrity Act (FMFIA). The following pages contain descriptions of our audit efforts in each of these areas, including an article on the ongoing financial accounting assistance our office is providing to the Office of the Chief Financial Officer (OCFO).

OPM's Consolidated Financial Statements Audit

As we have described in previous semiannual reports, our agency contracts with an independent public accounting (IPA) firm to perform OPM's consolidated financial statements audit. This fiscal year 2000 CFO Act audit relates to OPM's retirement, health and life insurance benefits programs, as well as its revolving fund (RF) and salaries and expense (S&E) accounts. The IPA provides audit reports on: (1) the fairness of the consolidated financial statements and their conformance with generally accepted accounting principles;

(2) agency management's internal controls over financial reporting; and (3) agency management's compliance with laws and regulations.

This is the first year that OPM has issued consolidated financial statements. In prior years, OPM prepared separate financial statements for each benefits program, revolving fund, and salaries and expense accounts. Our office monitored the IPA's performance to ensure that all work was conducted in accordance with the contract and in compliance with government auditing standards and other authoritative references pertaining to OPM's financial statements. Specifically, we participated in the planning, performance and reporting phases of the audit through participation in key meetings and review of the IPA's work papers and reports.

Based on our monitoring efforts, we concurred with the IPA's reports on the consolidated financial statements, internal controls, and compliance with laws and regulations. A summary relating to this audit report appears below.

OPM's FY 2000 Consolidated Financial Statements

Report No. 4A-CF-00-00-074
February 16, 2001

Under a contract monitored by our office, the international accounting firm of KPMG LLP (KPMG) performed audits of OPM's FY 2000 consolidated financial statements. KPMG's audit covered the retirement, health and life insurance programs, revolving fund (RF) and salaries and expense (S&E) accounts. As we have mentioned in previous semiannual reports, the benefits programs are key to the flow of benefits to federal civilian employees, annuitants and their respective dependents, and operate under the following names: the Civil Service Retirement System, the Federal Employees Retirement System, the Federal Employees Health Benefits Program, and the Federal Employees' Group Life Insurance program. These programs are administered by OPM's Retirement and Insurance Service.

Consolidated & Benefits Programs Financial Statements

KPMG determined that the consolidated fiscal year 2000 financial statements and the individual statements of the three benefits programs were presented fairly in all material respects and were prepared in conformance with generally accepted accounting principles.

KPMG noted improvements in the internal control environments of all three benefits programs as well as continued areas of concern in the RF and S&E accounts during fiscal year 2000. KPMG considered these latter issues in the RF and S&E accounts to be reportable conditions. *Reportable conditions* are defined as items that if left uncorrected could jeopardize the agency's ability to record, process, summarize and report financial data accurately, although they would ***not*** result in material misstatements to the consolidated financial statements. If the items ***would*** result in material misstatements, then they are defined as *material weaknesses*.

Table 1 on the next page includes reportable conditions that KPMG identified during its audit work on the financial statements. This was the first time since the CFO Act was implemented that none

OPM Improves Financial Management for FY 2000

Table 1: FY 2000 Internal Control Weaknesses

Issues	Retirement Program	Health Benefits Program	Life Insurance Program	Revolving Fund	Salaries & Expense Accounts
Controls Over Program Administration for the Community-Rated Health Carriers	N/A	RC	N/A	N/A	N/A
Quality Control Over Annual Financial Statement Preparation	NRC	NRC	NRC	RC	RC
Budgetary Accounting Structure	NRC	NRC	NRC	RC	RC
Account Analysis and Other Significant Reconciliation Procedures of OCFO	NRC	NRC	NRC	RC	RC
EDP General Control Environment	RC	RC	RC	RC	RC

RC = A reportable condition *NRC = No reportable condition* *N/A = Not applicable to the program*

Deficiencies Still Noted In OPM's Financial Reporting for FY 2000

of the reportable conditions was considered to be a material weakness in the agency's internal controls over financial reporting.

Specifically, KPMG reported the following conditions as needing improvement:

- Controls over program administration for community-rated health carriers.
- Quality control over annual financial statement preparation.
- Budgetary accounting structure of the Office of the Chief Financial Officer (OCFO)*

**Note: Budgetary accounts are included in two financial statements: the statement of budgetary resources and statement of financing. Without a set of self-balancing accounts to summarize budgetary activity, the risk of reporting inaccurate budgetary figures exists.*

- Account analysis and other significant reconciliation procedures of OCFO.
- Electronic data processing (EDP) general control environment:
- Service continuity (as it pertains to information resource protection and unplanned service interruption)
- Application change control/systems development
- Access controls
- Entity-wide information security program
- Chief Information Officer management, organizational and accountabilities structure

KPMG reported no instances of noncompliance that are required to be reported under government auditing standards or Office of Management

and Budget (OMB) Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*, except for the following areas where OPM's financial management systems did not substantially comply with the requirements of the Federal Managers' Financial Integrity Act:

- Federal financial management system requirements.
- Federal accounting standards (RF and S&E only).
- Standard general ledger at the transaction level (RF and S&E only).

OPM FACTS Transmissions Procedures

Our agency submits our consolidated financial statements (CFS) to the Department of the Treasury through FACTS (federal agencies centralized trial balance system). Treasury compiles and summarizes the FACTS data at the department level. As part of this process, it also requires selected agency Offices of the Chief Financial Officer and Offices of Inspector General (OIGs), including OPM, to compare and identify any differences between the FACTS data summarized by Treasury and an agency's consolidated financial statements submitted to the Office of Management and Budget (OMB). Treasury outlines specific procedures for OCFOs and OIGs to perform for this verification process.

We commented on FACTS procedures in our previous semiannual report, emphasizing their importance in preparing the government-wide consolidated financial statements and notes issued March 31 of each year. The notes are a vital component, reflecting both key accounting policies and procedures and other accounting data that assist the reader in interpreting the CFS. Treasury requires each agency's OCFO to transmit electronically a list of all standard general ledger accounts with preclosing balances prepared at fiscal year's end and the notes. What appears to be a simple procedure of transmitting and verifying data is complicated by the many transmissions and parties involved.

For the FY 2000 verification, insufficient planning and control over this process continued to impede successful completion by financial managers. Despite these difficulties, we performed the agreed-upon procedures prescribed by OMB, the U.S. Treasury and the General Accounting Office (GAO). In prior years, OPM did not prepare or transmit consolidated agency financial statements or provide all of the required documentation necessary to perform the verification procedures required by Treasury. Consequently, we could not perform the specific agreed-upon procedures. Instead, our OIG and KPMG performed other procedures to ensure that a verification process was completed.

Our FY 2000 verification identified the following two differences between the FACTS data summarized by Treasury and OPM's consolidated financial statements submitted to OMB:

- An accounts receivable amount was understated on the Treasury-summarized FACTS data by $3 million.
- The line item total entitled "Liabilities & Net Position" was understated on the Treasury-summarized FACTS data by $24.2 million.

In addition, OPM is required to provide explanations for any differences that are identified. As of the date of our agreed-upon procedure report to OMB, the U.S. Treasury and GAO, OPM management was still researching the differences we identified.

OIG and KPMG Note Disparities in FACTS Data

Auditors Note OPM's Commitment to Reporting Accurate Performance Data

Performance Audits

The purpose of our performance audits is to provide an independent assessment of how well our agency operates its various programs and activities. These audits help improve public accountability and facilitate decisionmaking by those within the agency responsible for implementing changes in those programs and activities. We conduct two types of performance audits: (1) *economy and efficiency audits*, and (2) *program audits*.

Economy and efficiency audits determine:

- Whether the agency is acquiring and managing resources (personnel, property and space) prudently and proficiently and the causes of any practices that do not lend themselves to economy and efficiency.
- Whether the agency has complied with laws and regulations relating to its operations.

Program audits determine:

- The extent to which the desired results or benefits established by the Congress or another authorizing body are being achieved.
- The effectiveness of organizations, programs, activities or functions.
- Agency compliance with significant laws and regulations.

During this reporting period, we again concentrated our performance audit efforts on program audits. Specifically, we reviewed documentation relating to our agency's Government Performance and Results Act (GPRA) data.

The Government Performance and Results Act, enacted in 1993, is commonly referred to as the Results Act or by its acronym GPRA. It was designed to produce improvements in government performance and accountability in federal programs and includes directives for federal agencies and departments to follow regarding strategic planning and performance management processes that emphasize goal-setting, customer satisfaction and results measurements. In an October 1998 congressional request, the IG community was asked to include in its semiannual reports to Congress a summary of reportable actions resulting from OIG activities. The following paragraphs describe our activities and results during this reporting period.

Verification and validation reviews. We issued a draft report to OPM management regarding our verification and validation reviews. The objectives of our reviews were to: (1) verify and validate performance data for selected FY 2000 GPRA performance indicators in our agency's performance report, and (2) evaluate the effectiveness of controls over performance measurement data.

We focused our reviews on key OPM program offices and important performance goals and measures for FY 2000.

The OPM performance plan submitted to Congress with its FY 2000 budget request established five general agency goals, 117 program goals, and 458 performance indicators. We selected 116 performance indicators from 42 program goals to verify and validate from eight major program offices. Included in our selection were many of the goals that relate to our top management issues reported to members of the House and Senate in letters dated December 1, 2000. A description of the top management issues and the status of OPM's actions on these issues appear in Table 2 on the next page.

Table 2: Summary of Top Management Issues

Issue Reported	Previously Included in Top Management Issues?	Agency Actions
OPM's Financial Management Oversight of the FEHBP (CRC enrollment reconciliations)	Yes	OPM is developing a centralized enrollment system. The system requirements are being defined and a pilot process is expected to be completed in the next year.
Reconciliation of OPM's Fund Balance with Treasury Account	Yes	OCFO has devoted significant resources to resolving this issue in the last three years. OCFO has improved reconciliation procedures, but there were still large differences between cash balances as of the end of FY 2000. Resolution is not expected in the short term.
Data Reconciliation and Control	Yes	OCFO has developed detail reports supporting general ledger balances to be used in reconciliations. OCFO has increased the level of contractor support in assisting with creating and revising transaction codes, and recently implemented several critical transaction codes. OCFO has assigned responsibility for all transaction code work to a senior-level manager.
Revolving Fund and Salaries & Expense Accounts Financial Statement Preparation	Yes	OCFO has contracted for help with development of needed transaction codes, improved the audit trail for year-end adjusting entries. OPM prepared a Statement of Financing, including RF and S&E accounts, in its FY 2000 consolidating financial statements.
Retirement Systems Modernization (RSM)	Yes	OPM has put in place an RSM project team for reengineering business processes related to the federal civilian retirement program.
OPM's GPRA Implementation	Yes	OPM is planning to strengthen its data validation and verification procedures, will ensure that the next performance report more clearly describes the link between each performance measure and overall strategic goals and more clearly explain how continuing goals and objectives address the agency's management challenges. OPM's Office of Executive Resources Management (OERM) will have numerical data checked by more than one person to ensure accuracy. However, OERM does not have the resources, nor do they see the benefit of establishing a complex data control process, to track and analyze this information.
Human Resources Management	Yes	OPM has designed a work force planning model that will allow line managers to analyze their current work force. Also, OPM performs oversight reviews in federal agencies covering human resource management areas, including reviews of agency adherence to merit system principles.
Health Care Fraud and Abuse in the Federal Employees Health Benefits Program	Yes	OPM management and the OIG have worked together to have legislation amended. Though an amendment has been included in at least four bills introduced in the 106th Congress, none has passed to date.

Auditors Review OPM's FMFIA Compliance Efforts

While we found that OPM needs to improve controls over the performance reporting process, we are encouraged that OPM management has been responsive to our findings and recommendations and has already taken steps to implement some improvements.

Performance reporting is still a new process to the federal government. While improvement and better guidance is needed, OPM is committed to presenting accurate and consistent data. With each year, OPM has gained experience in reporting its performance results. The following are areas within OPM program operations we identified in our verification and validation reviews that need to be addressed and improved:

- Establishing policies and procedures for obtaining and compiling performance data.
- Better oversight and monitoring of performance data by OPM managers.
- Better documentation for supporting performance data.
- Disciplined use of cutoff controls (specific time frames) to coincide with performance data.
- More reliable performance data.
- Performance results that correlate to pertinent measures.
- Availability of measurement data to support performance results.

While not all program offices had the same issues described in the preceding bullets, all of these deficiencies point to the need for OPM's performance results to be accurate and reliable.

As we continue to oversee the agency's compliance with the Results Act, our evaluators and auditors will continue to provide oversight and assistance to the agency in preparing its strategic plans, along with the agency's annual performance plans and reports.

OCFO's FMFIA Compliance Efforts

We reviewed OPM's Federal Managers' Financial Integrity Act (FMFIA) reporting process for FY 2000. Specifically, we examined documentation supporting the FMFIA process, comparing it to the results from our consolidated financial statement audits, required by the CFO Act.

We also analyzed management's summary of FMFIA internal control weaknesses and financial system nonconformances and found it to be complete. OPM reported four material weaknesses (as defined on page 23), four weaknesses it corrected in FY 2000, but are still subject to validation, three material nonconformances, and one material nonconformance that was corrected and now subject to validation. A *nonconformance* is defined as an agency's accounting system that does not conform to the principles, standards and related requirements prescribed by the U.S. Comptroller General.

In our opinion, the results of our and KPMG's work provide sufficient evidence to support the overall conclusion reached by OPM. OCFO has been working diligently to correct the control weaknesses reported, and is making progress in many areas.

OIG Accounting Assistance

We have continued to work with the Office of the Chief Financial Officer (OCFO) to provide accounting assistance to help improve and correct some previously identified reportable conditions and material internal control weaknesses (see pages 24 and 25, respectively).

As we described in our semiannual report issued last fall, these areas include the agency's training and management assistance (TMA) program and OCFO's cash management and payroll accounting issues. We are encouraged by the progress OCFO has made in these areas, but significant improvements are still necessary to correct those designated as material weaknesses. We have described these reviews in more detail below.

Training management assistance. As of March 2001, the total difference in revenue balances between the general ledger and TMA's recordkeeping system is approximately $42 million. We are assisting OCFO in reconciling differences between TMA's recordkeeping system and the general ledger system by comparing individual project balances and transactions. Progress has been slow, due to the age of these projects and the large number of projects and minimal supporting documentation for the transactions in the general ledger system. We will continue working with OCFO to correct the TMA project balances in the general ledger.

Cash reporting process. Our efforts to improve internal controls over the agency's cash reporting process have been focused on two areas: (1) manual adjustments to the monthly cash management transactions report to the U.S. Treasury (reports otherwise generated automatically from the financial management system), and (2) reconciling the significant differences between OPM's cash management records and Treasury's records. OCFO began implementing these improvements during the latter part of FY 2000. We have reviewed the documentation since implementation and have noted that the new controls need to be applied more consistently.

Payroll outsourcing. As we described in our last semiannual report, an OIG and OCFO quality improvement team identified numerous problems within the payroll accounting process. At the same time, the quality improvement team was developing methods to correct some of the problems identified, while researching the various causes for others.

Since that report, OPM has decided to contract out our payroll activities to the General Services Administration (GSA). The technical term for this type of interagency support is called *"cross-servicing."* Our office is participating in this process to ensure that controls are in place to maximize the accuracy of OPM's payroll activities and GSA information transfers to OPM financial systems.

OIG Assists OCFO in Improving Controls Over Its Financial Activities

Investigative Activities

The Office of Personnel Management (OPM) administers benefits from its trust funds for all federal civilian employees and annuitants participating in the federal government's retirement, health and life insurance programs. These trust fund programs cover approximately 9.5 million current and retired civilian employees, their spouses and dependents (coverage for these latter two categories is limited by law) and disburse about $61 billion annually. Other responsibilities of the agency include administration of the Combined Federal Campaign (CFC). The investigation of potential fraud involving OPM's trust funds, the CFC, and other agency programs, along with employee misconduct and other wrongdoing, occupies the majority of our OIG investigative efforts.

During this reporting period, the majority of our case work involved fraud committed by individuals and corporate entities against the three trust fund programs (health, retirement and life insurance) administered by our agency on behalf of all civilian federal employees, retired annuitants and any dependents or spouses eligible to receive these program benefits.

We aggressively pursued criminal and civil prosecutions against all persons and businesses we identified as having engaged in some form of trust fund fraud. Our efforts resulted in ten arrests and ten convictions, along with $7,024,218 in judicial and administrative monetary recoveries. We opened 21 investigations, closed 19, and 69 were still in progress at the end of the period. For additional information on investigative activity during this reporting period, refer to Table 1 on page 34 of this section.

We received a total of 626 hotline calls and complaints during this reporting period that covered health care fraud, retirement fraud, as well as employee misconduct or other suspected wrongdoing by individuals. Information we obtain through these hotline calls, as well as written complaints received in the office, continue to be extremely helpful to us in our investigative efforts to protect the programs under the jurisdiction of our agency. Please consult page 36 in this section for additional statistical data relating to our OIG hotline and complaint activity.

Health Care-Related Fraud and Abuse

In keeping with the emphasis that Congress and various departments and agencies in the executive branch place on combating health care fraud, we coordinate our investigations with the Department of Justice (DOJ), the FBI, 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 actively with the various U.S. Attorney's offices in their efforts to further consolidate and increase the focus of investigative resources in those regions that have been particularly vulnerable to fraudulent schemes and practices engaged in by unscrupulous health care providers. Additionally, our office maintains a close liaison with other federal law enforcement agencies participating in health care fraud investigations throughout the country. As a consequence, we participate in many health-care fraud working groups that simultaneously represent governmental interests at the federal, state and local levels.

Settlement Yields $5.8 Million Recovery for FEHBP

Our OIG special agents also work closely with the numerous health insurance carriers participating in the FEHBP, providing an effective means for reporting instances of possible fraud by FEHBP health care providers and subscribers. Our investigators, of course, continue to have a close working relationship with OIG auditors on fraud issues that may arise during the course of FEHBP health carrier audits.

The following narratives describe three of the cases we closed in the area of health care fraud during this reporting period.

Major Hospital Chain Involved in Billing Fraud

Our OIG has been involved in an ongoing five-year investigation with the Department of Justice and other federal and state agencies regarding a national hospital chain, HCA-The Healthcare Company (formerly known as Columbia/HCA Healthcare Corporation).

HCA-The Healthcare Company allegedly conspired to defraud various government health insurance programs out of millions of dollars. These programs include Medicare; TriCare (the successor to CHAMPUS), which insures our military personnel, retirees and family members; the FEHBP; and Medicaid, a federally sponsored program administered by the states for the working poor and the indigent.

This investigation focused on Columbia HCA's outpatient billing practices for laboratory tests that later were determined not medically necessary or not ordered by physicians. Other billing violations involved falsifying diagnostic codes through *upcoding*. Upcoding occurs when treatment codes are changed to reflect some type of high-end service not performed to gain greater reimbursement from insurance companies.

On December 14, 2000, Columbia HCA agreed to a $745 million civil settlement with the Department of Justice. The FEHBP portion of the settlement was $5.8 million in restitution. An additional $2.5 million in lost investment income (interest) for the FEHBP trust fund is to be determined by the Justice Department at a later date.

CVS Subsidiary Engages in RX Drugs Billing Fraud

On February 21, 2001, the Department of Justice and the CVS Corporation signed a settlement agreement in which CVS agreed to pay the federal government $4 million. This payment was to resolve CVS's federal liability for the alleged submission of false prescription claims by Revco, a CVS subsidiary. The FEHBP portion of this payment is $300,000.

This settlement follows a four-year investigation of several pharmaceutical firms billing customers in full for only partially filled prescriptions. Revco billed FEHBP members and their insurance companies at full price for these prescriptions, while only providing them with the amount of a drug in stock at the time of pickup.

Under these circumstances, FEHBP members receiving less than what their prescriptions called for would then be asked to return to pick up the remainder of these prescriptions at a later date. On those occasions when members failed to return, the drugs would be returned to Revco's inventory. Afterwards, Revco failed to amend the insurance claims to reflect that patients received only a portion of their prescribed medications, resulting in Revco overbilling their customers' insurance carriers.

Medical Clinic Physician Involved in Major Billing Fraud

Our office participated in a three-year investigation concerning allegations that a Texas physician, Dr. Dipakkumar (Dipak) Patel, owner and operator of the Midland Walk-in Clinic in Midland, Texas, had engaged in health care fraud over several years. The alleged fraud resulted in millions of dollars being paid to Dr. Patel by federal health insurance programs as well as private insurance programs.

We were joined by the FBI, the Defense Criminal Investigative Service, the OIG at the Department of Health and Human Services, as well as the State of Texas Attorney General's office, in looking into this case. The investigation confirmed that Dr. Dipak Patel fraudulently billed various federal programs, including the FEHBP, as well as several private insurance programs, for $1.6 million during the period January 1, 1995 through July 22, 1999. Dr. Patel was able to do this by generating false diagnoses to justify billing unnecessary services.

On January 25, 2001, Dr. Patel was indicted by a federal grand jury in the Western District of Texas in Midland on 51 counts of mail fraud, one count of health care fraud, and seven counts of money laundering. A trial date is expected to be set for late August or early September 2001. The outcome of this case will be reported in a later semiannual report.

To protect the interest of the FEHBP and its subscribers, in the interim, our office recently suspended both the physician and his clinic from participating in the FEHBP.

Retirement Fraud and Special Investigations

In addition to health care fraud, our office works closely with other federal, state and local law enforcement officials to uncover fraud involving OPM's retirement and life insurance program trust funds.

Our office's proactive efforts to identify fraud against OPM's retirement fund takes two forms: (1) we routinely review Civil Service Retirement System (CSRS) annuity records for indications of unusual circumstances, and (2) we maintain contact with the federal annuitant population, including telephone calls and on-site visits to the homes of annuitants listed in OPM's retirement records. While our fraud recoveries in this area are, for the most part, smaller than in the health care fraud area, criminal prosecutions and sentences tend to be more significant.

In addition, this office conducts special investigations in other areas having to do with serious criminal violations and misconduct by OPM employees. These cases primarily involve the theft of government funds and property.

Cited below are three retirement fraud investigations that were completed during this reporting period.

CSRS Annuity Overpayment Linked to Son

Our office initiated an investigation of the son of a deceased CSRS annuitant living in Phoenix, Arizona, who was alleged to have received CSRS annuity benefits intended for his deceased father for a period of 14 years following the father's death in 1977. The son received over $414,600 in annuity funds to which he was not entitled during this period.

West Texas Provider Indicted for Health Care Fraud Totaling $1.6 Million

CSRS Trust Fund Receives $197,033 in Settlement Agreement

Based on our investigation, and with the assistance of the U.S. Secret Service, the son was indicted in June 1995 in U.S. District Court in Phoenix, Arizona, on one count of theft of government funds and one count of making false statements to the government.

In June 1996, the U.S. Attorney's office in Phoenix dismissed the indictment against the annuitant's son, deciding instead to proceed with a civil action against him. In November 1998, the U.S. Attorney's office and the Phoenix bank where the annuity funds were deposited entered into an agreement that provided for the bank to reimburse the federal government $100,000 for a breach of contract claim. It did so, although not admitting guilt, for allegedly failing to notify the government when it learned of the annuitant's death in 1978.

In January 1999, the annuitant's son and his parents' estate filed for bankruptcy. Afterwards, in November 30, 1999, the Department of Justice and the annuitant's son and the parents' estate reached a negotiated agreement wherein the house owned by them jointly would be sold and the proceeds from the sale would be assigned to the government. The amount of $197,033 was returned to the federal government as a result of the sale of the house in December 2000.

Daughter of CSRS Retiree Guilty of Annuity Fraud

In January 1998, our special agents began investigating a case of annuity fraud involving a New York City resident named Judy Bennett, the daughter of a deceased Civil Service Retirement System (CSRS) annuitant.

Table 1: Investigative Highlights

Judicial Actions:	
Arrests	10
Indictments	12
Convictions	10
Administrative Actions[1]:	0
Judicial Recoveries:	
Fines, Penalties, Restitutions and Settlements	$6,755,379
Administrative Recoveries:	
Settlements and Restitutions	$268,839
Total Funds Recovered	**$7,024,218**

[1]*Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.*

With the cooperation and assistance of the New York City Office for Public Assistance, the U.S. Secret Service, and the OIG at the Social Security Administration, our investigators were successful in confirming that over a 13-year period, the daughter of this annuitant had illegally used her father's retirement benefits during this period. These CSRS annuity benefits totaled $122,262 during this time frame.

After failing to notify OPM of her father's death in 1983, Ms. Bennett was able to access the deceased annuitant's retirement benefits through an account they shared. These government annuity payments were deposited electronically to the joint account.

Ms. Bennett plead guilty to theft of government funds in U.S. District Court in New York City in July 2000. Appearing again in that court on December 1, 2000, she was sentenced to six months' home confinement, three years of supervised probation, and was ordered to make restitution to the government for the full amount of $122,262 she had illegally received.

Annuitant's Son Admits to Retirement Fraud

In a proactive attempt to identify annuity fraud, special agents from our office routinely check the validity of annuitant's addresses and other identifying information. During August 1999, our special agents discovered that a CSRS annuitant residing in Fairfax County, Virginia, had actually died in 1986.

Further investigation disclosed that the deceased annuitant's son, Norman Johnston, had access to these benefits through a bank account held jointly by Mr. Johnston and his mother. Access was further facilitated since these CSRS annuity benefits were deposited electronically into the account.

After being arrested on July 10, 2000, the annuitant's son pleaded guilty to wire fraud. On October 27, 2000, in U.S. District Court in Alexandria, Virginia, Mr. Johnston was sentenced to six months' home confinement with electronic monitoring, two years of supervised probation, 100 hours of community service, and ordered to make restitution in the amount of $66,247 to the government. This amount was in addition to the $16,454 previously recovered from the joint account, for a total of $82,701.

Restitution of $122,262 Ordered Following Conviction

OIG Hotlines and Complaint Activity

The information we receive on our OIG hotlines is generally concerned with 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 the agency.

In addition to hotline callers, we receive information from individuals who choose to write letters or who appear in our office. Those who report information can do so openly, anonymously or confidentially without fear of reprisal.

Retirement Fraud and Special Investigations

The Retirement and Special Investigations hotline provides the same assistance as traditional OIG hotlines in that it is used for reporting waste, fraud and abuse within the agency and its programs.

The Retirement and Special Investigations hotline and complaint activity for this reporting period included 86 telephone calls, 46 letters, 5 agency referrals, and 66 complaints initiated by the OIG, for a total of 203. Our administrative monetary recoveries resulting from retirement and special investigation complaints totaled $114,266.

Health Care Fraud

The primary reason for establishing an OIG hotline was to handle complaints from subscribers in the Federal Employees Health Benefits Program administered by OPM. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP.

While the hotline is designed to provide an avenue to report fraud by subscribers, health care providers or FEHBP carriers, frequently callers have requested assistance with disputed claims and services disallowed by the carriers. Each caller receives a follow-up call or letter from either the OIG hotline coordinator, the insurance carrier or another OPM program office as appropriate.

The Health Care Fraud hotline and complaint activity for the reporting period involved 165 telephone calls and 258 letters, for a total of 423. During this period, the administrative monetary recoveries pertaining to health care fraud complaints totaled $154,733.

OIG-Initiated Complaints

As illustrated earlier in this section, we respond to complaints reported to our office by individuals, government entities at the federal, state and local levels, as well as FEHBP health care insurance carriers and their subscribers. We also initiate our own inquiries as a means to respond effectively to allegations involving fraud, abuse, integrity, and occasionally malfeasance. Our office will initiate an investigation if complaints and inquiries can be substantiated.

Table 2: Hotline Calls and Complaint Activity

Retirement and Special Investigations Hotline and Complaint Activity:		
Retained for Investigation		132
Referred to:	OIG Office of Audits	0
	OPM Groups and Offices	41
	Other Federal Agencies	30
	Total	**203**
Health Care Fraud Hotline and Complaint Activity:		
Retained for Investigation		198
Referred to:	OPM Groups and Offices	93
	Other Federal/State Agencies	42
	Health Insurance Carriers or Providers	90
	Total	**423**
	Total Contacts	**626**

An example of a specific type of complaint that our office will initiate involves retirement fraud. This might occur when our agency has already received information indicating an overpayment to an annuitant has been made. At that point, our review would determine whether there were sufficient grounds to justify our involvement due to the potential for fraud. There were 18 such complaints associated with agency inquiries during this reporting period.

Another example of an OIG-initiated complaint occurs when we review the agency's automated annuity records system for certain items that may indicate a potential for fraud. If we uncover some of these indicators, we initiate personal contact with the annuitant to determine if further investigation is warranted. This investigative activity resulted in 48 instances where our office initiated personal contacts to verify the status of the annuitant.

We believe that these OIG initiatives 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.

OIG Proactive Efforts Help Thwart Annuity Fraud

Index of Reporting Requirements

Inspector General Act of 1978
(as amended)

Appendix I: Final Reports Issued With Questioned Costs October 1, 2000 to March 31, 2001

	Subject	Number of Reports	Questioned Costs[1]	Unsupported Costs[1]
A.	Reports for which no management decision had been made by the beginning of the reporting period	19	$ 65,673,570	$5,611,160
B.	Reports issued during the reporting period with findings	30	214,341,387	898,354
	Subtotals (A+B)	49	280,014,957	6,509,514
C.	Reports for which a management decision was made during the reporting period:	18	62,449,122	5,636,708
	1. Disallowed costs		59,329,197	5,636,708
	2. Costs not disallowed		3,119,925	0
D.	Reports for which no management decision has been made by the end of the reporting period	31	217,565,835	872,806
	Reports for which no management decision has been made within 6 months of issuance	3	8,106,692[2]	0

[1] *Questioned costs represent recommendations for recovery of funds resulting from OIG audits. Unsupported costs are included in questioned costs.*

[2] *Resolution of this item has been postponed at the request of the OIG.*

Appendix II: Final Reports Issued With Recommendations for Better Use of Funds October 1, 2000 to March 31, 2001

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

Appendix III: Insurance Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject *(Standard Audits)*	Issue Date	Questioned Costs	Unsupported Costs
1A-10-82-00-026	*Blue Cross and Blue Shield of Kansas in Topeka, Kansas*	*October 12, 2000*	*$852,317*	*$*
1A-10-34-00-065	*Blue Cross and Blue Shield of North Dakota in Fargo, North Dakota*	*October 12, 2000*		
1C-RR-00-00-067	*Prudential HealthCare HMO – Oklahoma City in Houston, Texas*	*October 12, 2000*		
TW-00-99-058	*PCA Health Plans of Texas in Louisville, Kentucky*	*October 12, 2000*	*1,218,341*	
1C-N9-00-00-068	*Geisinger Health Plan in Danville, Pennsylvania*	*October 16, 2000*		
10-55-96-032	*Independence Blue Cross in Philadelphia, Pennsylvania*	*October 18, 2000*	*73,273,083*	
1A-10-57-00-034	*Highmark Blue Cross and Blue Shield in Pittsburgh, Pennsylvania*	*October 23, 2000*	*990,060*	
10-06-99-055	*CareFirst Blue Cross and Blue Shield in Owings Mills, Maryland*	*November 13, 2000*	*5,996,561*	*25,548*
PW-00-00-006	*Community Health Plan dba Kaiser Permanente in Latham, New York*	*November 20, 2000*	*51,714*	
H8-00-00-010	*United HealthCare Select in Minneapolis, Minnesota*	*December 8, 2000*	*11,130,140*	
V8-00-00-001	*Aetna U.S. HealthCare of the Mid-Atlantic in Blue Bell, Pennsylvania*	*December 11, 2000*	*20,866,353*	
68-00-99-043	*Harvard Pilgrim HealthCare, Inc., in Dedham, Massachusetts*	*December 11, 2000*	*477,539*	
10-85-99-054	*CareFirst Blue Cross and Blue Shield in Washington, D.C.*	*December 20, 2000*	*5,468,489*	
75-00-96-029	*Humana Michael Reese HMO Plan in Chicago, Illinois*	*January 16, 2001*	*7,763,346*	*872,806*
1A-10-31-00-069	*Wellmark Blue Cross and Blue Shield of Iowa in Des Moines, Iowa*	*January 17, 2001*	*248,781*	

Appendix III: Insurance Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject *(Standard Audits)*	Issue Date	Questioned Costs	Unsupported Costs
1A-10-95-00-033	*Trigon Blue Cross and Blue Shield in Richmond, Virginia*	*January 17, 2001*	*$ 556,165*	*$*
1A-10-53-01-010	*Blue Cross and Blue Shield of Nebraska in Omaha, Nebraska*	*January 19, 2001*	*166,135*	
1C-GF-00-00-003	*PacifiCare of Texas in Dallas, Texas*	*January 29, 2001*	*4,598,962*	
1D-87-00-00-030	*Hawaii Medical Service Association in Honolulu, Hawaii*	*January 31, 2001*	*752,425*	
1A-10-74-01-024	*Wellmark of South Dakota in Sioux Falls, South Dakota*	*February 5, 2001*		
UR-00-96-030	*Humana Health Plan of Texas in San Antonio, Texas*	*February 9, 2001*	*26,057,092*	
1A-10-11-00-035	*Blue Cross and Blue Shield of Massachusetts in Boston, Massachusetts*	*February 15, 2001*	*1,157,851*	
1A-10-84-01-002	*Blue Cross and Blue Shield of Utica-Watertown in Utica, New York*	*February 15, 2001*	*37,490*	
D2-00-96-028	*Humana Health Plan of Louisville in Louisville, Kentucky*	*February 22, 2001*	*8,190,253*	
1A-10-69-01-001	*Regence Blue Shield in Seattle, Washington*	*February 22, 2001*	*342,322*	
1C-SU-00-00-007	*Aetna U.S. HealthCare of Philadelphia in Blue Bell, Pennsylvania*	*February 22, 2001*	*9,811,061*	
1C-JC-00-00-002	*Aetna U.S. HealthCare of New York in Blue Bell, Pennsylvania*	*February 26, 2001*	*13,439,139*	
1A-10-12-01-011	*Blue Cross and Blue Shield of Western New York in Buffalo, New York*	*March 1, 2001*	*100,125*	
1C-UM-00-00-022	*NYLCare Health Plans of the Gulf Coast, Inc., in Houston, Texas*	*March 5, 2001*	*1,030,560*	
TM-00-00-009	*QualMed Washington Health Plan in Bellevue, Washington*	*March 5, 2001*	*175,614*	

Appendix III: Insurance Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject *(Standard Audits)*	Issue Date	Questioned Costs	Unsupported Costs
1C-TX-00-01-029	*Humana Health Plan of Texas, Inc., in Corpus Christi, Texas*	*March 6, 2001*	*$*	*$*
1A-10-55-00-063	*Independence Blue Cross in Philadelphia, Pennsylvania*	*March 12, 2001*	*1,250,027*	
1C-P3-00-00-008	*Aetna U.S. HealthCare of New Jersey in Blue Bell, Pennsylvania*	*March 13, 2001*	*14,242,064*	
1C-JB-00-00-019	*Prudential HealthCare HMO of the Mid-Atlantic in Baltimore, Maryland*	*March 16, 2001*	*1,420,963*	
1B-45-00-00-064	*Claims Administration Corporation as Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland*	*March 26, 2001*	*2,676,415*	
TOTALS			*$214,341,387*	*$898,354*

Appendix IV: Internal Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-CF-00-00-074	*Office of Personnel Management's Fiscal Year 2000 Consolidated Financial Statements*	*February 16, 2001*	*$*	*$*
TOTALS			***$***	***$***

Appendix V: Information Systems Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
4A-OP-00-00-075	*Critical Infrastructure Protection in Presidential Decision Directive 63 in Washington, D.C.*	*December 15, 2000*	*$*	*$*
1B-47-00-00-027	*Information System General Controls at American Postal Workers Union Health Plan in Silver Spring, Maryland*	*January 2, 2001*		
TOTALS			***$***	***$***

Appendix VI: Combined Federal Campaign and Other External Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
3A-CF-00-00-060	*The 1997 and 1998 Combined Federal Campaigns for Military, Veterans and Patriotic Service Organizations of America in Corte Madera, California*	*October 16, 2000*	*$*	*$*
3A-CF-00-00-059	*The 1997 and 1998 Combined Federal Campaigns for Health and Medical Research Charities of America in Corte Madera, California*	*October 23, 2000*		
3A-CF-00-00-058	*The 1997 and 1998 Combined Federal Campaigns for Animal Funds of America in Corte Madera, California*	*October 23, 2000*		
3A-CF-00-00-061	*The 1997 and 1998 Combined Federal Campaigns for Christian Service Charities in Springfield, Virginia*	*November 27, 2000*		
3A-CF-00-00-031	*The 1997 and 1998 Combined Federal Campaigns for the Heartland in Kansas City, Missouri*	*November 30, 2000*		
3A-CF-00-00-062	*The 1997 and 1998 Combined Federal Campaigns for Earth Share in Washington, D.C.*	*December 5, 2000*		
3A-CF-00-00-050	*The 1997 and 1998 Combined Federal Campaigns for the National Capital Area in Washington, D.C.*	*December 19, 2000*		
3A-CF-00-00-025	*The 1997 and 1998 Combined Federal Campaigns of Santa Clara/San Benito Counties in Santa Clara, California*	*January 16, 2001*		
3A-CF-00-00-045	*The 1997 and 1998 Combined Federal Campaigns of Central Ohio in Columbus, Ohio*	*February 9, 2001*		

Appendix VI: Combined Federal Campaign and Other External Audit Reports Issued October 1, 2000 to March 31, 2001

Report Number	Subject	Issue Date	Funds Put to Better Use	Questioned Costs
3A-CF-00-01-035	*The 1998 and 1999 Combined Federal Campaigns of Southern New Jersey in Rancocas, New Jersey*	*March 20, 2001*	*$*	*$*
6A-2A-00-00-070	*Costs Incurred by Aramark Services, Inc., under Contract OPM-96-BPO5508 in Charlottesville, Virginia*	*January 31, 2001*		
6A-2A-00-01-030	*Cost Proposal by Wastren, Inc., to Provide Services at the Federal Executive Institute in Charlottesville, Virginia*	*March 15, 2001*		
TOTALS			***$***	***$***

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