

*Office of the Inspector General*

*October 1, 2003 — March 31, 2004*

# Semiannual Report

## TO CONGRESS



*United States Office of Personnel Management*



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OFFICE OF  
THE INSPECTOR GENERAL

UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT  
WASHINGTON, D.C. 20415-1100

*April 30, 2004*

*Honorable Kay Coles James  
Director  
U.S. Office of Personnel Management  
Washington, D.C. 20415*

*Dear Mrs. James:*

*I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period October 1, 2003 to March 31, 2004. 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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## Foreword

I take great pleasure in acknowledging the absolute and unprecedented support the Office of Inspector General receives from OPM Director Kay Coles James. In the past twelve months, the Office of the Inspector General (OIG) has experienced unparalleled growth and increased the number and quality of tools used by our auditors, investigators and administrative sanctions staff, thus expanding the scope of our activities. Our auditors and investigators today are better equipped to fulfill the OIG mission as stated in our office's FY 2003 – 2007 Strategic Plan:

*To provide objective and effective oversight with recommendations that safeguard integrity, efficiency and effectiveness of OPM services and programs.*

This growth has made it possible to accomplish many of the objectives we have aimed to achieve since the inception of our office as a statutory entity. We expect that our achievements as the result of our expanded capabilities will support continued growth in the future. Our positive growth during the year has included:

■ ***New Criminal Investigative Field Offices***

We have established 11 criminal investigative field locations throughout the United States. By strategically placing our investigative resources in the field, we are more effectively targeting fraud and other crimes against OPM programs. We are also building working relationships with other federal criminal investigators, United States Attorneys, and local law enforcement officials critical to timely referrals and successful investigations.

■ ***Permanent Law Enforcement Authority***

The Homeland Security Act of 2002 granted permanent law enforcement authority to special agents in our office and other statutory offices of Inspector General. Prior law enforcement authorization was derived from an administrative deputation process. This provides us capabilities equivalent to all other federal law enforcement agencies, including the authority to serve warrants, make arrests, and carry firearms. These are essential to our investigators' ability to fully contribute to federal law enforcement efforts in our principal investigative missions.

■ ***Administrative Sanctions Regulations***

We issued final regulations to implement the administrative sanctions authorities currently provided by the FEHBP statute—Title 5, United States Code, section 8902a—to address violations by health care providers. These include suspension and debarment provisions that protect FEHBP and its enrollees from untrustworthy providers, as well as civil monetary penalties that allow OPM to recover funds paid as the result of provider fraud or misconduct. In concert with our expanded investigative structure and capabilities, the administrative sanctions regulations represent an effective enforcement authority to address health care provider fraud within FEHBP.

■ *Enhanced Data Warehousing*

We have continued to increase our health benefit claims analysis capabilities through enhancements to our FEHBP claims data warehouse. For example, we have upgraded our computer equipment to better manage the extremely large data files associated with federal employees' health care records. This has facilitated several large-scale, program-wide audits to identify incorrect health benefits payments. We have also developed new applications and adapted existing applications to take advantage of the increased processing power and storage capacity of the new hardware.

■ *Global Claims Analysis*

By employing the benefits of our enhanced FEHBP claims data warehouse, our auditors were able to complete their first global claims analysis. Traditionally, our audits have been limited to analyzing claims only on an individual health plan basis. While this strategy has been effective in identifying millions of dollars in improper claim payments, a global audit strategy will enable us to identify the impact of a particular claim payment issue simultaneously across a large number of carriers. Based on the results of the first global study, as summarized in this report, we anticipate that this approach will generate significant savings to the FEHBP.

■ *Expanded Information Security Review*

Recognizing the critical importance of information technology (IT) security, as highlighted in the Federal Information Security Management Act (FISMA), we have instituted a continuous audit approach in our oversight of OPM's IT security environment. In prior years, we conducted one comprehensive review during a four-month period. Our expanded format will provide year-round oversight. This approach will offer the agency more timely feedback on potential security weaknesses rather than waiting for the annual review results. We believe that the continuous audit format will ensure that OPM remains proactive in securing its IT resources.

Our growth has been hard earned and reflects the outstanding and professional performance of our staff. We take pride in our past accomplishments and anticipate future achievements of even greater significance.



# Productivity Indicators

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## Financial Impact:

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Audit Recommendations for Recovery of Funds .....	\$55,105,062
Recoveries Through Investigative Actions .....	\$3,493,248
Management Commitments to Recover Funds .....	\$52,213,766

*Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.*

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## Accomplishments:

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Audit Reports Issued .....	45
Investigative Cases Closed .....	8
Indictments .....	9
Convictions .....	14
Hotline Contacts and Complaint Activity .....	506
Health Care Provider Debarments and Suspensions. ....	1,816
Health Care Provider Debarment and Suspension Inquiries .....	1,955



# Statutory and Regulatory Review

*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. Our review focuses on the impact of these proposals in 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.*

**W**e had no significant legislation to consider in this reporting period. However, we achieved significant accomplishments in our efforts to protect the Federal Employees Health Benefits Program (FEHBP) and its enrollees from untrustworthy health care providers through our administrative sanctions authorities.

## Health Care Provider Administrative Sanctions

### *Background*

Since 1993, the OIG has conducted an administrative sanctions program under a delegation of authority from the OPM Director. Sanctions are administrative enforcement measures that protect the FEHBP and its enrollees from health care providers who pose a financial risk to the program itself or a health care risk to persons who receive health insurance coverage through the FEHBP. The FEHBP administrative sanctions statute—Title 5, United States Code, section 8902a—identifies 18 types of violations for which a provider may be suspended or debarred. Of these, five also authorize imposition of financial penalties on health care providers who have improperly or wrongfully claimed payment of FEHBP funds.

- A *health care provider (provider)* is a physician, hospital, clinic, or any other person or entity that, either directly or indirectly, furnishes health care services or supplies. Services or supplies includes diagnoses, procedures, treatments, drugs, medications, appliances, equipment, or any other item used for health care purposes. A person or entity may be an “indirect” provider if they support or facilitate the activities of a direct provider. For example, the owner of a medical clinic is considered a health care provider, even if he/she does not directly participate in care or treatment of patients.
- *Debarment* is an administrative action that disqualifies a health care provider from receiving payment of FEHBP funds for items or services furnished to an FEHBP-covered person for a specified period of time. OPM gives a provider advance notice of a proposed debarment and the opportunity to present opposing information to the debaring official.
- *Suspension* has the same effect as a debarment in stopping payments to a provider, but becomes effective immediately, without prior notice or procedural rights. Suspensions are issued for limited periods of time, pending the outcome of an investigation or judicial action when there is reliable evidence that a provider may pose a risk to the health or safety of FEHBP-covered persons.

**Over 25,000  
Active FEHBP  
Debarments**

**Civil  
Monetary  
Penalty  
Regulations  
Go Into Effect**

- *Financial sanctions* may consist of a *civil monetary penalty*, which carries a fine of up to \$10,000 for each item a provider has claimed falsely, wrongfully, or improperly from FEHBP, and/or an *assessment* of up to twice the amount of each item claimed. Providers against whom OPM proposes to levy financial sanctions have essentially the same pre-sanction procedural rights as those who are proposed for debarment.

*Workload Indicators*

- During this reporting period, our office issued 1,816 debarments and suspensions of health care providers from participating in the Federal Employees Health Benefits Program (FEHBP).
- As of the end of the reporting period, there were 25,553 active FEHBP debarments and suspensions of health care providers.
- Our office responded to 1,955 inquiries related to FEHBP administrative sanctions during the reporting period.

*Managing and Improving  
Administrative Sanctions Activities*

On a long-term and continuing basis, our office is committed to implementing administrative sanctions in the most efficient manner possible, consistent with overall program effectiveness. We make a systematic effort to apply automated technology in every aspect of the sanctions workload. During the reporting period, our office completed several projects that improved the management of our administrative sanctions activities. These include:

- *Issuing comprehensive sanctions regulations.* We completed the comprehensive revision of regulations implementing the FEHBP administrative sanctions statute with issuance of final financial sanctions regulations in the *Federal Register* (69 FR 9919) on March 3, 2004. As noted in several prior editions of the OIG semiannual report, where we tracked the progress of these regulations through the rule-making process, civil monetary penalties and assessments have dual purposes. First, they are intended to allow FEHBP to recover its costs and financial losses attributable to false, fraudulent, and wrongful claims. Additionally, the civil monetary penalties in particular are expected to act as a deterrent on future claims-related misconduct. While we do not anticipate issuing financial sanctions with the same frequency as debarments and suspensions, we review every debarment case to determine its potential suitability for financial sanctions.

- *Expanding and updating guidelines for FEHBP carriers.* The FEHBP provides health coverage through 127 insurance carriers which have contracted with OPM. Claims processing and payment are performed by each carrier. Therefore, the carriers themselves are the critical points at which suspensions and debarments are actually applied to the payment of funds. The FEHBP provider sanctions statute and OPM regulations place direct responsibility on the carriers for the following actions:

- Denying payment to suspended or debarred providers.
- Notifying their FEHBP membership about the suspension or debarment of their providers.

- Reporting to OPM regarding sanctions enforcement activities.
- Applying a set of waivers and exceptions to protect the interests of FEHBP-covered persons. These authorize the following payments to debarred providers:
  - For services furnished in emergency situations.
  - In cases when OPM determines that no equivalent alternative sources of care exist in a community.
  - When the covered person did not know, and could not reasonably be expected to know, that their provider was suspended or debarred.

We developed the first set of sanctions implementation guidelines for carriers in 1993, shortly after the administrative sanctions program began operation, and we have regularly updated them to reflect the program’s development. However, the complete revision of the sanctions regulations necessitated a virtually total redrawing of the guidelines.

The new guidance includes additional information about the OIG’s decision-making processes in sanctions cases, as well as sample correspondence that either OPM or the carriers will need. We improved the usefulness of the guidelines by directly addressing the carriers’ roles under the statutory sanctions system and the various information management technologies that we have introduced to improve sanctions operations (see following article). We circulated a draft version of the guidelines to a selected sample of FEHBP carriers for their review and comment. Through this process, we received a substantial number of insightful recom-

mendations for further improvements, many of which we incorporated in the final version issued to the carriers.

- *Applying information technology to improve program performance.* Administrative sanctions work involves activities that are typically data-intensive, including:
  - Obtaining information regarding potentially sanctionable violations by providers.
  - Establishing and maintaining case records.
  - Issuing written notices within statutory and regulatory timeframes.
  - Informing FEHBP carriers and other federal agencies of suspensions and debarments.

Throughout the existence of the administrative sanctions program, we have sought to resolve workload concerns associated with handling large amounts of information by developing or applying automated technologies. The initiatives we completed during the reporting period are summarized below.

- *Expanding secure communications with FEHBP carriers.* Prompt and detailed communication between OPM and carriers on sanctions matters is essential, but the large number of FEHBP carriers who must receive our program-related information requires a specialized methodology. Further, because of the sensitivity of much of the information involved in administrative sanctions actions, communication must take place through a secure channel.

For several years, we have been successfully using a secure webpage within the official OPM website to post encrypted lists of suspensions and debarments for carriers to download. However, with the implementation of the statutory sanctions authority, the range of our communications with carriers has become much broader.

During the reporting period, we expanded the webpage to include all sanctions program-related information that is usable by carriers. Among the added material are the new carrier guidelines, the regulations associated with the FEHBP sanctions statute, the text of the statute itself, and a summary of the legal authorities for debarments and suspensions. As a result of work we performed during the reporting period, all material posted on the webpage also meets federal “section 508” accessibility requirements.

- *Reporting sanctions data government-wide.* Executive Order 12549 (February 18, 1986), “Debarment and Suspension,” its implementing regulations, and subsequent legislation such as the Federal Acquisition Streamlining Act of 1994, have established the principle that a debarment issued by any agency applies to the debarred party’s participation in all federal programs. The General Services Administration (GSA) maintains a comprehensive government-wide list, the Excluded Parties List System (EPLS), of all federally-debarred and suspended persons and business entities. The list is publicly available via the Internet at <http://epls.arnet.gov>.

Under a recent GSA-sponsored “e-government” initiative, each agency became directly responsible for entering data regarding its sanc-

tions into EPLS online. The only means provided for this purpose was a line-by-line manual entry system. Many agencies issuing a relatively small number of sanctions found the workload impact of this data entry to be minimal. However, at current levels, the burden on our office would have exceeded 350 entries per month (each containing numerous lines of information regarding sanctioned providers), which represented an unacceptable increase for us. Therefore, in coordination with GSA’s staff and their e-government contractor, our office developed a custom program and associated procedures that allow us to upload material from our own database into the EPLS database, without any manual data entry. This process not only avoids the workload burden that we would otherwise have faced but is also more efficient than the system that existed before the e-government initiative, where we supplied hardcopy data to GSA for centralized data entry.

- *Obtaining information relevant to sanctionable violations.* Administrative sanctions offices government-wide are beginning to use electronic information media—including Internet sites—as sources of “lead” or background information. As much or more than other federal debarment authorities, the FEHBP provider sanctions statute is designed to allow prompt action against providers who have committed violations indicating that they pose risks to FEHBP-covered persons and insurance carriers. For example, certain types of criminal convictions form the basis for mandatory debarment by our office and carry a mandatory minimum period of debarment. Further, administrative appeals other than reconsideration processes through the debarring

official are not available for any case in which the facts have previously been adjudicated by a federal, state, or local judicial or regulatory body. In this context, we believe that our office should be able to efficiently turn information obtained electronically into proposed sanctions.

We began an exploratory project during the reporting period to determine the extent to which information necessary for suspension or debarment decisions was available from electronically-accessible sources. Our preliminary conclusion is that sufficient sources of relevant, reliable, and credible information exist, either freely available on the Internet or through on-line subscriptions at very modest costs, to warrant their regular use in preparing administrative sanctions cases.

Especially useful were the official websites of federal, state, and local prosecuting attorneys, courts, regulatory agencies, and health care licensing boards, as well as health insurance carriers, health care newsgroups, and commercial sites offering data compiled from public record sources on persons and business entities. Even in cases where the on-line information was incomplete, we were frequently able to obtain additional data by referring to the contact person or “links” listed on a site.

## **Administrative Sanctions Issued During Reporting Period**

### ***Physician Suspended by State Regulatory Board***

During the reporting period, our OIG Office of Investigations identified the case of a Seattle-area obstetrician-gynecologist who was suspended by the Washington

State Department of Health because of charges that he had sexually assaulted a patient at his clinic. Concurrently, the Department’s Medical Quality Assurance Commission was also considering action on other charges against the physician, including negligence, substandard quality of care, and professional incompetence.

The OIG determined that this provider had treated FEHBP enrollees recently and had received payment of FEHBP funds for those services. Further, he had been a network provider for a major FEHBP carrier for at least two years, until being terminated from the network several years ago because of billing irregularities.

OPM’s regulations require the following three elements in order to suspend a health care provider:

- Credible evidence that the provider has committed a violation for which debarment could ultimately be imposed.
- Submission of claims to an FEHBP carrier, or membership in a provider network of a FEHBP carrier.
- Conduct indicating that the provider poses a risk to the public interest (either FEHBP-covered persons or the FEHBP itself).

In this case, all three criteria were clearly present and well-documented in either the official records of the Medical Quality Assurance Commission or the files of FEHBP carriers. Therefore, our office suspended this doctor in February 2004. Concurrently, we also suspended his wholly-owned clinic. Both suspensions will remain in effect until the Washington State Department of Health takes final action with regard to the doctor’s right to practice medicine, at which time we will consider whether debarment may be appropriate.

## **Physician Suspended for Sexual Assault Charges**



**Pediatric  
Allergist  
Suspended  
After Fraud  
Indictment**

*Provider Indicted for Health Care Fraud*

In January 2004, a physician specializing in pediatric immunology and allergies was indicted for health care fraud in the U.S. District Court for the Western District of Texas. The indictment charged that this doctor submitted health insurance claims for allergy tests that had not been performed. These involved and were supported by documents giving false diagnoses regarding the existence of patients’ allergies. We determined that this provider was, at the time of his indictment, a member of the preferred provider network of a large FEHBP carrier, and had been receiving payments of FEHBP funds for several years.

The indictment constitutes a finding of probable cause that the physician committed the offense with which he is charged. As such, it represents prima facie evidence that a potentially debarable violation has occurred. Further, we concluded that the provider was creating a health risk by knowingly generating improper and inaccurate medical records on his patients—some of whom were under 2 years old. If relied upon by other providers, these false records could result in misdiagnosis and improper treatment. Therefore, our office suspended the physician and his wholly-owned clinic pending the outcome of the criminal case against the doctor.

*Convictions of Seven Physicians Associated with Pain Management Clinic*

Using on-line and other electronically accessible research sources, we developed information regarding sanctionable violations by a group of seven physicians associated with a pain management clinic in Myrtle Beach, South Carolina. These providers were convicted or pled guilty to federal criminal charges of conspiracy, money laundering, improper prescribing of controlled substances, and health care fraud.

The principal conspirator was a physician who had conducted a neurology practice in Myrtle Beach for several years. In 1996, he was charged by the South Carolina Board of Medical Examiners with unethical sexual conduct with patients and inappropriate prescription practices involving painkilling medications. The doctor litigated these and other charges before the medical board over a 5-year period, during which his license was twice revoked and restored and his right to prescribe medication was terminated. Ultimately, in 2001, he permanently surrendered his licensure to practice medicine in South Carolina.

During the pendency of his disputes with the medical board, the doctor developed a scheme to maintain his medical practice. He established a “pain management center” in North Myrtle Beach and recruited several other physicians who were will-



ing to issue prescriptions for painkilling medications such as Oxycontin, Percocet, and hydrocodone, among others, without appropriate medical examinations or consideration of medical necessity. At its peak, the clinic was reported to have illegally distributed painkilling medication to hundreds of persons each day, many of whom traveled great distances to Myrtle Beach, drawn by the immediate availability of these substances from the clinic.

In August 2002, a grand jury of the U.S. District Court for South Carolina handed down a 93-count indictment against the clinic owner, six other physicians he employed at the clinic, and other clinic employees. A search of the clinic by law enforcement officials revealed large amounts of controlled substances, cash, at least six semiautomatic assault rifles, other rifles, shotguns, handguns, and approximately 20,000 rounds of ammunition. The clinic owner, facing several criminal counts that could have resulted

in life sentences, agreed to plead guilty to health care fraud, conspiracy to possess and distribute controlled substances, and conspiracy to launder money. He ultimately received a sentence of 15 years' incarceration, followed by three years of supervised probation. In a series of cases during 2003, convictions or guilty pleas were secured against the six other indicted physicians for prescription fraud and/or money laundering.

The FEHBP administrative sanctions statute calls for mandatory debarment of providers convicted of criminal offenses related to controlled substances, health care fraud, or financial crimes associated with providing health care services. Therefore, we debarred all seven of these physicians from participation in the FEHBP. Because of his primary role in organizing the conspiracy and other aggravating factors involving the South Carolina Board of Medical Examiners' actions against his license, we imposed the longest period of debarment—20 years—on the clinic owner.

## **Seven Physicians Debarred after Convictions for Improperly Prescribing Controlled Substances**



# Audit Activities

## Health and Life Insurance Carrier Audits

*The Office of Personnel Management contracts with private-sector firms to underwrite and provide health and life insurance benefits to current and retired federal employees as well as their dependents and survivors through the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program (FEGLI). Our office is responsible for auditing these benefits program activities to ensure that these various insurance entities meet their contractual obligations with our agency.*

Our audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to contracts not being renewed or because of plan mergers and acquisitions. Annual premium payments are approximately \$27 billion.

The health insurance plans that our office is responsible for auditing are comprised of *community rated* and *experience-rated* carriers. Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). Experience-rated carriers are mostly fee-for-service plans, the largest being the Blue Cross and Blue Shield health plans, but also include experience-rated HMOs.

The two types of carriers differ in the way they calculate premium rates. Community rated carriers generally set their subscription rates based on the average revenue needed to provide health benefits to each member of a group, whether that group is from the private or public sector. Rates established by experience-rated plans reflect a given group's projected paid claims, administrative expenses and service charges for administering a specific group's contract. With respect to the Federal Employees Health Benefits Program, each experience-rated

carrier must maintain a separate account for its federal contract, adjusting future premiums to reflect the FEHBP group enrollees' actual past use of benefits.

During the current reporting period, we issued 25 final reports on organizations participating in the FEHBP, of which 16 contain recommendations for monetary adjustments in the aggregate amount of \$55.1 million due the FEHBP.

While the summaries below represent only a small portion of our auditing efforts, they are indicative of the various types of reviews conducted by this office. A complete listing of all health plan audit reports issued during this reporting period can be found in Appendices III (pages 38-39) and V (page 40).

### Community-Rated Plans

Our community-rated HMO audit universe of FEHBP participating plans covers approximately 150 rating areas throughout the country. Community-rated audits are designed to ensure that plans charge the appropriate premium rates within their service areas in accordance with their contracts and applicable federal regulations.

The rates health plans charge the FEHBP are derived predominantly from two rating methodologies—*community rating by class* and *adjusted community rating*.

**Inappropriate  
Health Benefit  
Charges Exceed  
\$1.2 Million**

The key rating factors for community rating by class are age and sex distribution of a group’s enrollees. In contrast, adjusted community rating projects the use of benefits by a group, using actual claims experience adjusted for expected increases in medical costs. However, once a community rate is set, it may not be adjusted to actual costs incurred.

The regulations governing the Federal Employees Health Benefits Program require each carrier to certify that the FEHBP is being offered rates equivalent to the rates given to the two groups closest in subscriber size to the FEHBP (known as *similarly sized subscriber groups*, or SSSGs). The carrier does this by submitting a certificate of accurate pricing.

The rates charged are set by the FEHBP participating carrier, which is responsible for selecting the two appropriate groups. Should our auditors later determine that equivalent rates were not applied to the FEHBP, they will report a condition of *defective pricing*. When this occurs, the FEHBP is entitled to a decrease in the rate to compensate for any overcharges.

During this reporting period, we issued 12 audit reports on community-rated plans. These reports contain recommendations for OPM’s contracting officer to require the plans to return approximately \$36 million to the FEHBP.

**Prudential HealthCare  
HMO – Tennessee**

**in Memphis, Tennessee**

Report No. 1C-UB-00-02-033  
March 1, 2004

Prudential HealthCare HMO – Tennessee provides primary health care services to its members in the Memphis, Tennessee

area. The plan began its participation in the FEHBP as a community-rated comprehensive medical plan in 1982. The plan was acquired by Aetna Health, Inc. in 1999. Our audit covered contract years 1997 through 2000 and was conducted at the plan’s offices in Alpharetta, Georgia. The FEHBP paid the plan about \$48 million in premiums from 1997 through 2000.

In conducting the audit, we found that the FEHBP was overcharged a total of \$1,212,428 for inappropriate health benefit charges in 1997 and 1999. In addition, we determined that the FEHBP was due \$350,299 for lost investment income. *Lost investment income* represents the interest the FEHBP would have earned on the money the plan overcharged as a result of defective pricing. The plan believes that the FEHBP is entitled to a price adjustment of \$689,290, plus lost investment income.

The primary objectives of the audit were to determine if:

- The plan offered the FEHBP market price rates.
- The loadings to the FEHBP were reasonable and equitable. A *loading* is the cost for additional benefits purchased by a group to enhance the basic benefits package for its members.
- The plan developed the premium rates in accordance with the laws and regulations governing the FEHBP.

*Defective pricing.* We determined that the FEHBP did not receive a rate discount equivalent to the largest discount the plan gave to one of the SSSGs in contract years 1997 and 1999. In 1997, the largest discount given to a similarly sized group amounted to 4.16 percent. In contrast, the FEHBP did not receive a discount. After applying the 4.16 percent discount to the FEHBP audited rates, we determined that the FEHBP had been overcharged \$378,041.

We found that in 1999 the plan gave one of the similarly sized subscriber groups a discount amounting to 4.538 percent, but did not give the FEHBP a discount. Additionally, in developing its rates, the plan used higher value factors to determine the expected medical and pharmacy costs to the FEHBP than it used for the SSSGs. The plan was unable to support the factors used for the FEHBP. We computed the rates that should have been charged to the FEHBP by applying the 4.538 percent discount to the annual medical and pharmacy trend factors the plan used for the SSSGs. In comparing the rate we developed to the rates the plan charged the FEHBP, we determined that the FEHBP was overcharged \$834,387.

We calculated that an additional \$350,299 was due the FEHBP for investment income it lost through December 31, 2003. Additional lost investment income is due for the period beginning January 1, 2004, until all questioned costs have been returned to the FEHBP.

## **HealthAmerica Pennsylvania, Inc.**

### **in Harrisburg, Pennsylvania**

Report No. 26-00-98-015  
December 4, 2003

Report No. 1C-26-00-018  
December 1, 2003

HealthAmerica Pennsylvania, Inc. began its participation in the FEHBP in January 1986 as a community-rated comprehensive medical plan. The plan provides primary health care services to its members in the Pittsburgh and Harrisburg areas, as well as certain other counties in Pennsylvania. The audits of the plan covered contract years 1993 through 1999 and identified over \$32 million in ques-

tioned costs, including lost investment income. Based upon concern over the issues discussed below, we referred the audit results to the Department of Justice (DOJ) for further review. Subsequent discussions involving the plan, DOJ and our office led to a negotiated settlement under which the plan agreed to return \$29,006,771 to the government.

A primary objective of the audits was to determine if HealthAmerica Pennsylvania, Inc. met its contractual obligation to provide the FEHBP the same premium rate discounts it gave to the two subscriber groups closest in size to the FEHBP. The audits showed that, although the FEHBP was charged the appropriate rates in 1998 and 1999, it did not receive the discounts it should have received in 1993 through 1997.

*Defective pricing.* We found that the plan could not support the enrollment information used to develop the rates for the FEHBP and the SSSGs in 1993 through 1996. It could not provide documentation showing actual group enrollment. Also, the plan did not always select the appropriate similarly sized subscriber groups. In addition, we determined that the FEHBP rates were not developed in a manner consistent with the plan's own rating policy.

Because of inadequate demographic information and inconsistent application of the plan's rating methodology, we redeveloped the rates for the FEHBP and SSSGs based on a standard rating methodology. This methodology applied standard state filed rates for specific benefit levels and was, in fact, used by the plan to rate groups with fewer than 3,000 employees.

For 1993, our analysis showed that the billed rates for the plan's SSSGs for its Pittsburgh and Harrisburg regions were lower than the rates we developed using the standard rating methodology by

**Plan Agrees  
to Return Over  
\$29 Million**

12.31 percent and 9.62 percent, respectively. When we applied these discounts to the audited FEHBP rates, we found that the FEHBP was overcharged by \$982,014 in the Pittsburgh region and \$1,734,688 in the Harrisburg region. Similar results were found in 1994, 1995, and 1996, with total overcharges for these years amounting to \$5.2 million, \$2.8 million, and \$2.9 million, respectively.

In 1997, the plan again had a problem selecting the appropriate SSSGs. We disagreed with both of its selections for the Harrisburg region and with one group for the Pittsburgh region. Also, the plan could not provide support for the demographics it used to calculate various factors used to develop the premium rates for the FEHBP and SSSGs. Therefore, we compared the rates billed to the similarly sized groups to the standard rates the plan filed with the state of Pennsylvania. We found that the largest discount received by an SSSG in either region amounted to 11.87 percent. We then developed FEHBP audited rates for both regions based on the standard state filed rates and applied the 11.87 percent discount. A comparison of these rates to the rates actually charged the FEHBP showed that the FEHBP was overcharged \$5,581,167 in the Harrisburg region and \$3,099,858 in the Pittsburgh region.

We also determined that the FEHBP was due a total of \$10,312,276 for lost investment income for 1993 through 1997 overcharges.

### Experience-Rated Plans

The Federal Employees Health Benefits Program offers a variety of experience-rated plans, including fee-for-service plans, which constitute the majority of federal contracts in this category. Also included are employee organizations that sponsor or operate health benefits plans and comprehensive medical plans that

participate as experience-rated rather than community-rated HMOs.

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

- Appropriateness of contract charges and the recovery of applicable credits, including refunds, on behalf of the FEHBP.
- 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 12 audit reports on experience-rated plans. These audits consisted of seven Blue Cross and Blue Shield plans, three employee organization plans and two experience-rated comprehensive medical plans.

In these reports, our auditors recommended that OPM's contracting officer require the plans to return \$19 million in inappropriate charges and lost investment income to the FEHBP related to these disallowed charges.

### *BlueCross BlueShield Service Benefit Plan*

The Service Benefit Plan is administered by the BlueCross BlueShield Association (BCBS Association), which contracts with OPM on behalf of its BCBS member plans across the country. Approximately 53 percent of all FEHBP subscribers are enrolled in Blue Cross and Blue Shield plans. Participating Blue Cross and Blue Shield plans independently underwrite and process the health benefits claims of their respective federal subscribers.



The BCBS Association through its Washington office provides centralized management for the BCBS Service Benefit Plan and oversees a national operations center. The operations center activities include:

- Verifying subscriber eligibility.
- Approving or disapproving reimbursement of local plan FEHBP claims payments (using computerized system edits).
- Maintaining an FEHBP claims history file and an accounting of all FEHBP funds.

We issued seven Blue Cross and Blue Shield experience-rated reports during the reporting period. Our auditors noted \$18,608,622 in questionable contract costs charged to the FEHBP and an additional \$484,976 in lost investment income on these questioned costs, totaling \$19,093,598 owed to the FEHBP. Of the \$18,608,622 in questioned costs, the BCBS Association agreed with \$15,836,948.

### *Global Coordination of Benefits for Blue Cross and Blue Shield Plans*

Report No. 1A-10-00-03-013  
March 31, 2004

This was a limited-scope audit of 59 Blue Cross and Blue Shield plans to determine if they complied with FEHBP contract provisions regarding coordination of benefits (COB) with Medicare.

*Coordination of benefits* occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays

its benefits as the primary payer and the other insurer pays a reduced benefit as the secondary payer. Health insurers generally refer to the National Association of Insurance Commissioners' guidelines to determine which coverage is primary. Medicare is usually the primary payer when the insured is covered under an FEHBP plan.

*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 care services. Part B also helps pay for covered doctor services that are medically necessary.

The Medicare program is administered by the Centers for Medicare and Medicaid Services, an agency within the Department of Health and Human Services.

Our auditors identified over 66,063 possible uncoordinated claim lines (individual charges relating to a claim) for the period October 1, 2000 through December 31, 2001. Based upon our review, we determined that 43,564 claim lines were not properly coordinated with Medicare. Each of the 59 plans reviewed failed to coordinate at least some of its claims. As a result, the FEHBP paid as the primary insurer for these claims even though Medicare Part A or B was the primary insurer.

We estimated that these BCBS plans overcharged the FEHBP \$10,135,466 for the COB payment errors. The BCBS Association agreed with \$9,891,276 and disagreed with \$244,190 of the questioned claim overcharges.

**Uncoordinated  
Claims  
Payments  
with Medicare  
Costs FEHBP  
\$10.1 Million**

**Auditors Determine \$4.8 Million Owed the FEHBP**

For 96 percent of the erroneous claim lines in question, we found that the BCBS claims system did not identify Medicare as the primary payer when the claims were paid. Further, when Medicare information subsequently became available, the plans did not retroactively coordinate the patients' prior claims with Medicare.

We recommended that the contracting officer disallow these uncoordinated claim payments and instruct the BCBS plans to recover the overpayments from the healthcare providers, crediting all amounts recovered to the FEHBP.

***Anthem Blue Cross and Blue Shield of Indiana***

**in Indianapolis, Indiana**

Report No. 1A-10-39-03-004

March 1, 2004

Our audit of the FEHBP operations at Anthem Blue Cross and Blue Shield of Indiana (Anthem BCBS of Indiana) took place at the plan's offices in Mason, Ohio and Indianapolis, Indiana. The purpose of this audit was to determine whether the plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the FEHBP contract.

Our auditors reviewed health benefit payments made by the plan from contract years 1999 through 2001, as well as miscellaneous payments and credits, administrative expenses, and cash management activities covering these same contract years. During this period, Anthem BCBS of Indiana charged approximately \$391 million in health benefit costs and administrative expenses to the contract.

As a result of this audit, our auditors determined that inappropriate charges to the FEHBP totaled:

- \$1,194,016 in health benefit charges.
- \$3,152,867 in administrative expense charges.

The BCBS Association agreed with most of the questioned charges. Lost investment income on the questioned charges totaled \$467,650. Our auditors determined that the FEHBP was owed a total of \$4,814,533.

**Health Benefits**

For the audited years, Anthem BCBS of Indiana paid \$322 million in FEHBP claim payments. In conducting our audit, we reviewed claim payments for proper pricing and payment. We also reviewed specific financial and accounting areas, such as refunds and other miscellaneous credits relating to FEHBP claim payments.

*Claim payment errors.* For the period January 1, 1999 through December 31, 2001, we sampled claims to determine if Anthem BCBS of Indiana had paid claims properly. Our auditors identified 292 claim payment errors, resulting in overcharges of \$1,194,016 to the FEHBP.

Consequently, we recommended that the contracting officer disallow these 292 claim payment overcharges and instruct the plan to recover the overpayments, crediting all amounts recovered to the FEHBP.

**Administrative Expenses**

For contract years 1999 through 2001, Anthem BCBS of Indiana charged the FEHBP \$69 million in administrative expenses. We determined that \$3,152,867 of these expenses, the majority of which related to pension costs, were not allowable under the FEHBP contract.



*Pension costs.* Under the terms of the FEHBP contract, Anthem BCBS of Indiana was allowed to charge the FEHBP for costs related to its employee pension plan. However, federal regulations limited the amount of pension costs that could be charged to the contract to the lower of:

- The amount contributed to the employee pension fund, or
- The amount of pension expense calculated in accordance with the Cost Accounting Standards (CAS).

Our auditors concluded that the plan did not adhere to regulatory limits for charging pension cost allocations for 1999 through 2001. Even though pension costs were zero using CAS computation, the plan charged the FEHBP \$1,884,581. The BCBS Association agreed with this finding.

### ***Blue Cross and Blue Shield of Kansas City***

#### **in Kansas City, Missouri**

Report No. 1A-10-42-02-070  
December 10, 2003

Our auditors performed a limited-scope audit of the FEHBP operations at Blue Cross and Blue Shield of Kansas City (BCBS of Kansas City) covering contract years 1999 through 2001. For this audit, the auditors focused on claim payments made by the plan, as well as miscellaneous payments and credits, and cash management.

The primary objectives of this audit were to determine if the plan:

- Complied with the FEHBP contract provisions on benefit payments.
- Properly charged miscellaneous payments to the FEHBP.
- Promptly returned refunds and miscellaneous credits relating to health benefit payments to the FEHBP.
- Handled FEHBP funds in accordance with applicable laws and federal regulations concerning cash management in the FEHBP.

We questioned \$1,338,970 in health benefit refunds, \$225,058 in claim payment errors, and \$141,744 in excess drawdowns of FEHBP funds. Of the \$1,705,772 in questioned charges, the BCBS Association agreed with \$1,660,908 and is researching \$44,864.

### **Employee Organization Plans**

Many federal employee organizations sponsor or operate experience-rated FEHBP plans. The largest employee organizations are federal employee unions and associations, such as the American Postal Workers Union, the National Association of Letter Carriers, the Government Employees Hospital Association, and the Special Agents Mutual Benefit Association.

During the reporting period, we issued three audit reports for employee organization plans. These reports examined the Mutual of Omaha Insurance Company as underwriter for the Rural Carrier Benefit Plan, the Foreign Service Benefit Plan and the Association Benefit Plan.

**Auditors  
Question  
\$1.7 Million  
in Payments**

**Auditors  
Question  
\$127,000 in  
Health Benefit  
Charges**

***Mutual of Omaha  
Insurance Company  
as Underwriter for the  
Rural Carrier Benefit Plan***

**in Omaha, Nebraska**

Report No. 1B-38-07-02-104  
December 23, 2003

Enrollment in the Rural Carrier Benefit Plan is open to federal employees and annuitants who are members of the National Rural Letter Carriers' Association. As of December 31, 2001, membership totaled approximately 42,000 federal enrollees.

Our auditors performed a limited-scope audit of the FEHBP operations at Mutual of Omaha for contract years 1999 through 2001. We reviewed health benefit payments for proper pricing and payment, coordination of benefits with Medicare, and potential duplicate payments. During this period, Mutual of Omaha paid \$675 million in actual claim payments for the Rural Carrier Benefit Plan.

We questioned \$127,176 in health benefit charges. Mutual of Omaha agreed with all of the questioned charges.

The significant findings included:

*Duplicate claim payments.* We selected and reviewed a sample of 444 potential duplicate claim payments. Based on our review, we determined that 97 of the 444 claim payments in our sample were duplicates, resulting in overcharges of \$105,761 to the FEHBP. Therefore, we recommended that the contracting officer disallow these duplicate payments, directing Mutual of Omaha to recover the overpayments.

*Coordination of benefits with Medicare.* For claims paid during the period October 2001 through December 2001, our

auditors identified 5 hospital claim payments, totaling \$8,174, and 25 physician claim payments, totaling \$15,253, which the FEHBP improperly paid as primary insurer when Medicare Part A or B was the primary insurer. We estimated that this failure to coordinate benefits with Medicare for these 30 claim payments resulted in overcharges of \$18,967 to the FEHBP.

We recommended that the agency's contracting officer disallow these uncoordinated claim payments and instruct Mutual of Omaha to collect these payments and credit all overpaid amounts to the FEHBP.

**Experience-Rated  
Comprehensive Medical Plans**

Experience-rated comprehensive medical plans offer what is termed a *point of service* product. That is, members have the choice of using a designated network of providers or using non-network providers. A member's choice in selecting one health provider over another has obvious 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.

During the reporting period, we issued two experience-rated comprehensive medical plan audit reports for Coventry Health Care of Iowa (*Report No. 1D-SV-00-03-076*) and Optima Health Plan (*Report No. 1D-9R-00-03-093*). For each plan the objective of the audit was to determine whether the plan's management fees charged to the FEHBP for contract year 2001 were expenses incurred in accordance with the terms of the contract and applicable federal regulations. Neither of these audits disclosed any findings.

## Information Systems Audits

*Computer-based information and its accessibility have become increasingly important to the Office of Personnel Management and its programs. We perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program. We also audit elements of the agency's computer security environment.*

OPM relies on computer technologies and information systems in one form or another to carry out its work in administering various operations, including programs that distribute health and retirement benefits to millions of current and former federal employees. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal computer based programs could have a harmful effect, compromising efficiency and effectiveness and ultimately increasing the cost to the American taxpayer.

Our office examines the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits. *General controls* refer to the policies and procedures that apply to an entity's overall computing environment. *Application controls* are those directly related to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions.

### *Audit of Information Systems General and Application Controls at BlueCross BlueShield of Florida*

**in Jacksonville, Florida**

Report No. 1A-10-41-03-026  
February 3, 2004

BlueCross BlueShield of Florida (BCBSF) processes the claims of FEHBP subscribers through its facilities located in Jacksonville, Florida. BCBSF's contract covers nearly 150,000 current and former federal employees and their families at a cost to the FEHBP of \$600 million annually in health care premiums.

This was our first information systems audit at BCBSF. Our review examined both general controls and application controls. While the general controls review centered on the Plan's overall computer-based operating environment, our application control review focused on BCBSF's claims processing and check-writing systems. We also evaluated BCBSF's compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Our review of HIPAA requirements is necessitated by the impending implementation of new privacy, security and electronic claims filing regulations.

## BCBSF Agrees with OIG Recommendations to Improve Information System Controls

During the audit, we evaluated the confidentiality, integrity and availability of BCBSF’s computer based information systems. We determined that BCBSF had a number of security controls in place that helped promote a secure computer environment. We noted, in particular, that these included:

- Controls over the configuration and administration of the mainframe operating platform and access control software.
- Adequate application development and program change controls, including a defined system development lifecycle methodology.
- Routine maintenance of critical environmental systems to ensure the availability of computing, network, and voice systems within the data center.
- Appropriate input, processing and output controls in the claims system.
- Significant progress towards compliance with HIPAA requirements.

However, we found information systems internal controls could be improved and noted that BCBSF should:

- Address several elements essential in its security policy for ensuring its ability to maintain a sound security posture.
- Ensure all employees are aware of procedures to identify and report security incidents.
- Implement a formal security awareness program for its full-time, part-time, and temporary associates; vendors and contractors.
- Address aspects of its personnel policies and procedures essential to maintain accountability for new employees and protect the confidentiality of its information when employees leave.

BCBSF officials have agreed to address the above system vulnerabilities by carrying out our recommendations.

## Other External Audits

*We conduct audits of the local organizations of the Combined Federal Campaign (CFC), the only authorized fundraising drive conducted in federal installations throughout the world. Also, at the request of Office of Personnel Management procurement officials, our office performs pre- and post-award contract audits related to the acquisition of goods and services by agency program offices.*

## Combined Federal Campaign

Under Executive Order 10927 (August 18, 1961), “Abolishing the President’s Committee on Fundraising Within the Federal Service and Providing for the Conduct of Fundraising Activities,” the U.S. Civil Service Commission (OPM’s predecessor) was given the responsibility to arrange for national voluntary health and welfare agencies to solicit funds from federal employees and members of the armed services at their places of employment. Since then, OPM’s role has been further defined through additional executive orders, a public law (P.L. 100-202), and new federal regulations (5 CFR 950). Key responsibilities now include:

- Providing eligibility guidelines for national and local organizations and charities participating in the Combined Federal Campaign (CFC).
- Specifying the role of local CFCs.
- Overseeing the CFC operations.

A total of 355 local campaigns operating in the United States and overseas participated in the 2002 Combined Federal Campaign. For that year, federal employee contributions reached \$237 million, while campaign expenses totaled \$21 million.

Campaigns are identified by geographical areas as specific as a single city, several cities or counties. Our auditors review the eligibility of participating charities associated with a given campaign and

the charities’ compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) conduct an audit of their respective financial activities. As part of our audits, we review the IPA reports.

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.

During this reporting period we issued nine audit reports on local CFCs and eight audit reports on national charitable federations that participated in the CFC.

### Local CFC Audits

The local CFC organizational structure consists of:

- *Local Federal Coordinating Committee (LFCC)*. The LFCC is comprised of federal employees and is responsible for organizing the local CFC, determining local charities’ eligibility to participate in the CFC, supervising the activities of the Principal Combined Fund Organization, and addressing any problems relating to a local charity’s noncompliance with the policies and procedures of the CFC.

## Audits Reveal Deficiencies in Conduct of Local CFC Campaigns

- *Principal Combined Fund Organization (PCFO).* The PCFO is a charity designated by the LFCC to be responsible for collecting and distributing CFC charitable funds, training volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during a given campaign.

- *Local Federations.* A local federation is an association of local charitable organizations with similar objectives and interests that provides common fundraising and administrative services to its members.

- *Individual charities.*

Our audits of local CFCs identified numerous violations of regulations and guidelines governing local CFC operations. Among the most frequently occurring problems were the following:

- *Local Applications.* 225 out of 328 local charities reviewed did not meet one or more of the eligibility requirements for the 2000 and 2001 CFC.

- *Federation Applications.* 15 out of 45 local federations reviewed did not meet one or more of the eligibility requirements for the 2000 and 2001 CFC.

- *PCFO Made Improper Expense Payments.* The PCFO for two CFCs paid for expenses associated with conducting the 2000 and 2001 campaigns with receipts from prior and current years' campaigns. Regulations require that they use their own funds and then obtain reimbursement from current year campaign receipts.

- *PCFO Reimbursement Policy.* The PCFO for one of the local campaigns we audited reimbursed itself for budgeted expenses rather than actual expenses, thereby violating CFC reimbursement regulations.

Recommendations made to the campaigns to address these audit results include:

- LFCCs ensure local organizations provide accurate supporting documentation to demonstrate that they meet the requirements of 5 CFR 950 and that they instruct PCFOs and local federations to maintain CFC documentation for three campaign years.

- LFCCs ensure all federations verify that their applications comply with 5 CFR 950 and OPM guidance.

- The PCFOs absorb the cost associated with conducting campaigns from their own funds and be reimbursed, or obtain a commercial loan to pay for costs associated with conducting the campaigns.

- The PCFO recover from the gross receipts of the campaign its expenses, approved by the LFCC, reflecting the actual cost of administering the local campaign.

### National Charitable Federation Audits

We also audit national charitable federations that participate in the CFC. National charitable federations are similar to local federations in providing common fundraising, administrative and management services to their members. For example, the Children's Charities of America is a national federation providing services to other charities concerned with the welfare of children. Our audits of national federations focused on the eligibility of member charities, distribution of funds and allocation of expenses.



## Summary of Audits of Combined Federal Campaign National Federations that Contracted with Maguire/Maguire, Inc. for Administrative and Marketing Services

As of the 2001 campaign, there were 23 national federations participating in the CFC, 12 of which contracted with Maguire/Maguire, a management consulting and marketing firm, for administrative services. In campaign 2001, the federations that contracted with Maguire/Maguire represented 620 charities and received pledges totaling \$42,021,972, or 17 percent of the total CFC pledges of \$241,573,254 for the campaign.

On April 11, 2002, our office received a letter from a coalition of federations alleging violations of the CFC regulations by the national federations contracting with Maguire/Maguire. The letter alleged the federations were violating the following regulations:

- 5 CFR 950.301(e)(3) which requires a federation to “*Certify that it does not employ in its CFC operations the services of private consultants, consulting firms, advertising agencies or similar business organizations to perform its policy-making or decision-making functions in the CFC.*”
- 5 CFR 950.203(a)(5) which requires a federation to “*Certify that the organization is directed by an active and responsible governing body whose members have no material conflict of interest, and, a majority of which serve without compensation.*”

- 5 CFR 950.203(a)(7) which requires a federation to “*Certify that its publicity and promotional activities are based upon its actual program and operations, are truthful and non-deceptive, and make no exaggerated or misleading claims.*”
- 5 CFR 950.202(a) which requires that a member of any national federation “*Certify that it provides or conducts real services, benefits, assistance, or program activities, in 15 or more different states or a foreign country over the 3 year period immediately preceding the start of the year involved. This requirement cannot be met on the sole basis of services provided through an ‘800’ telephone number or by sending materials via the U.S. Postal Service or a combination thereof.*”

In addition, OPM’s Office of CFC Operations (OCFCO) expressed concerns regarding the release of donor names to Maguire/Maguire by the federations and their member charities.

In response to the allegations, we audited each of the 12 federations that contracted with Maguire/Maguire to determine if they were in compliance with the CFC regulations cited in the allegations. In addition, we reviewed the financial management of the federations. The audits covered campaign years 1998 through 2001.

During this reporting period, we issued final reports for 8 of the 12 federations audited. The auditors found that there were numerous violations of the CFC regulations, although not of the severity claimed in the allegations. We found the following weaknesses:

- *Inadequate controls over CFC contributors list.* Eight federations allowed Maguire/Maguire to use the lists of donor names without the consent of the donors.

## **Audits of National CFC Federations Reveal Numerous Regulatory Violations**

- *Designations of contributions were not verified.* The Independent Certified Public Accountants' audit reports for the eight federations did not include verifications that designations of contributions made to charities were being honored as required by regulations.
- *Decision-making authority improperly delegated to contractor.* The process used by six of the federations to review member applications effectively delegated to Maguire/Maguire the decision-making function of deciding whether an applicant met one of the requirements for participation in the CFC.
- *Board of Directors size and term violations.* In four federations, the size of the Board of Directors was not in compliance with the federation bylaws, or a member of the board served for a period longer than the bylaws allowed.
- *Board member conflict of interest.* A board member of one federation had a conflict of interest because of a financial relationship with Maguire/Maguire.
- *Improper certification of member agencies.* One federation certified a charity for membership in its organization that had left it for another federation.

A listing of these reports can be found in Appendix VI on page 41-42.



## OPM Internal Audits

*We conduct and supervise independent and objective audits of the Office of Personnel Management's programs and administrative operations. We also perform evaluations and inspections of agency programs and operations. Two critical areas of ongoing audit activity include OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act), as well as the agency's work required under the Government Performance and Results Act of 1993 (Results Act or GPRA).*

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Internal controls provide reasonable assurance that program operations are:

- Effective and efficient.
- Characterized by reliable financial reporting.
- Compliant with applicable laws and regulations.

We conduct our activities in accordance with government auditing standards. We include OPM program managers in every step of the audit process to ensure that we have met their needs, addressed concerns and received feedback on how we can improve the value of our services. We believe this cooperative spirit ensures that all parties involved with our activities will obtain the maximum benefit and that we will continually improve our level of services.

## Government Performance and Results Act Audits

The Results Act was enacted to improve government performance and accountability through better planning and reporting of agency results. The act seeks to improve the efficiency, effectiveness, and public accountability of federal agencies as well as the information used for congressional decision-making.

Each agency is required under the Results Act to develop five-year strategic plans, annual performance plans and annual performance reports. These requirements create a recurring cycle, beginning with setting a strategic direction, followed by defining annual goals and measures, and, finally, reporting on performance.

The OPM Strategic Plan 2002-2007 was issued in November 2002. The strategic plan provides the framework for implementing the Results Act. OPM implements its strategic plan through an annual performance plan that includes goals and measures for key program offices. OPM describes its achievement of the goals and measures through the annual performance report. During this reporting period, we continued to review the agency's performance relating to the Results Act.

## OPM's Fiscal Year 2003 Annual Performance Data

During FY 2003, OPM implemented a restructuring plan and established TEAM OPM, a new, results-oriented structure that aligned the agency according to its new mission and strategic goals. As a result, OPM created a new FY 2003 performance plan that consolidated 10 overlapping performance goals in the original FY 2003 plan. The revised performance plan now contains 47 goals.

**Independent  
Public Firm in  
Full Compliance  
with Contract  
and GAS**

The objectives of our audit were to determine the accuracy and reliability of performance data for selected FY 2003 performance measures and to evaluate the effectiveness of controls over that data. We focused our audit on OPM’s main divisions by selecting 30 performance measures to verify and validate. The final report is now being prepared and will be discussed in the next semiannual report.

**OPM’s Consolidated Financial Statements Audits**

OPM’s consolidated financial statements include the retirement, health and life insurance benefit programs, the revolving fund (RF) and salaries and expenses accounts (S&E). The RF programs provide funding for a variety of human resource-related services to other federal agencies, such as pre-employment testing, security investigations, and employee training. The S&E accounts cover the costs of administering the operations of the agency.

OPM contracts with an independent public accounting firm, KPMG LLP (KPMG), to audit the agency’s annual consolidated financial statements under the requirements of the CFO Act. In performing these audits, KPMG is responsible for providing audit reports that contain KPMG’s opinion as to the fair presentation (absence of material misstatements) of OPM’s consolidated financial statements and their conformance with generally accepted accounting principles.

KPMG also reports on OPM’s internal control efforts concerning financial reporting and OPM management’s compliance with laws and regulations that could have a material impact on how the agency determines the financial statement amounts.

We monitor KPMG’s performance during these audits to ensure that they conduct their audits in accordance with the terms of the contract and in compliance with government auditing standards and other authoritative references, such as OMB Bulletin No. 01-02, *Audit Requirements for Federal Financial Statements*. Specifically, we are involved in the planning, performance and reporting phases of the audit through participation in key meetings and reviewing KPMG’s work papers and reports. Based on these efforts, we found that KPMG was in full compliance with the terms of the contract and government auditing standards (GAS).

***OPM’s FY 2003 &  
FY 2002 Consolidated  
Financial Statements***

Report No. 4A-CF-00-03-098  
December 29, 2003

KPMG also performed audits of the individual benefits programs’ financial statements. The benefits programs administer the flow of benefits to federal civilian employees, annuitants, and their dependents. They include the following specific programs and systems:

- Civil Service Retirement System
- Federal Employees Retirement System
- Federal Employees Health Benefits Program
- Federal Employees’ Group Life Insurance.

**Consolidated & Benefits Programs’  
Financial Statements**

KPMG determined that the fiscal years 2003 and 2002 consolidated financial statements, and the individual statements of the three programs that govern the retirement, health, and life benefits of federal employees and retirees, were presented fairly in all material respects and were prepared in conformance with generally accepted accounting principles.

KPMG noted three reportable conditions in the internal control environments of the benefits programs and the RF and S&E accounts during fiscal year 2003. Each of these conditions existed in the prior year and remains uncorrected. One other reportable condition from the prior year was corrected.

*Reportable conditions* are situations that if left uncorrected could jeopardize the agency’s ability to record, process, summarize and report financial data accurately. However, they would not result in material misstatements to the consolidated financial statements if not corrected.

A *material misstatement* is an inaccuracy of such magnitude that it is probable the judgment of a reasonable person relying on this misstatement would have been inappropriately changed or influenced. If an inaccuracy would result in a material misstatement, it is called a *material weakness*.

Table 1 includes reportable conditions that KPMG identified during its audit work on the financial statements for FYs 2003 and 2002. This is the fourth consecutive year that none of the reportable conditions identified during the audit was considered to be a material weakness in the agency’s financial reporting internal controls.

KPMG reported no instances of non-compliance that are required to be reported under government auditing standards or Office of Management and Budget Bulletin No. 01-02, except as noted in the table below. The following table lists the internal control weaknesses reported for FY 2003 and the programs to which they apply.

**OPM’s  
Financial  
Statements  
Receive “Clean”  
Audit Opinion**

**Table 1: FY 2003 Internal Control Weaknesses**

Issues	Retirement Program	Health Benefits Program	Life Insurance Program	Revolving Fund	Salaries & Expenses Accounts
Information Systems General Control Environment	Reportable Condition	Reportable Condition	Reportable Condition	Reportable Condition	Reportable Condition
Financial Management and Reporting Processes of OCFO	No Reportable Condition	No Reportable Condition	No Reportable Condition	Reportable Condition*	Reportable Condition*
Segregation of Duties over the Letter of Credit System for the Experience-Rated Carriers	Not Applicable	Reportable Condition	Not Applicable	Not Applicable	Not Applicable

\*U.S. Government Standard General Ledger at the transaction level



## Investigative Activities

*The Office of Personnel Management 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 over eight million current and retired federal civilian employees, including eligible family members, and disburse about \$77 billion annually. While we investigate employee misconduct and other wrongdoing brought to our attention, the majority of our OIG investigative efforts are spent examining potential fraud involving these trust funds.*

OIG's investigative activities achieved significant results during the reporting period. We opened 39 investigations and closed 8 with 89 still in progress at the end of the period. Our investigations also led to 4 arrests, 9 indictments, 14 convictions and monetary recoveries totaling \$3,493,248. For a complete statistical summary of our office's investigative activity in this reporting period, refer to Table 2 on page 33 along with the OIG's productivity indicators listed at the beginning of this report.

Most of our casework relates to the federal health, life and retirement trust fund programs that OPM administers. Our investigators aggressively pursue individuals and corporate entities seeking to defraud these trust funds upon which federal employees, retirees, their spouses and dependents rely.

Our investigators have worked a number of fraud cases involving the Civil Service Retirement and Disability trust fund. This trust fund program covers all civilian federal employees who contributed to the Civil Service Retirement System (CSRS) and/or the newer Federal Employees Retirement System (FERS). More retirees are covered by the CSRS retirement system than FERS because it is the older of the two. This makes the CSRS retirement system more vulnerable to fraud.

We identify fraud by proactively reviewing annuity records for irregularities, such

as individuals who have greatly exceeded normal life expectancy. We also receive information from our agency's Center for Retirement and Insurance Services (CRIS) through the computer matches it performs using OPM's annuity rolls and the Social Security Administration's death records to identify payments to deceased annuitants. These computer matches have proven very helpful to OPM since many CSRS annuitants or those receiving CSRS survivor benefits may also be eligible for Social Security benefits.

OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 506 formal complaints and calls on these hotlines during the reporting period. Additional information, including specific activity breakdowns for each hotline, can be found on pages 33 and 34.

In keeping with the emphasis that Congress and various departments and agencies in the executive branch have placed on combating health care fraud, we coordinate our investigations with the Department of Justice (DOJ) and other federal, state and local law enforcement agencies. At the national level, we are participating members of DOJ's health care fraud working groups. We actively work with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most common.

In addition to our responsibility to detect and investigate fraud perpetrated against OPM's trust funds, we conduct investigations of criminal violations and misconduct by OPM employees.

While the summaries below represent only a small portion of our activities, they are indicative of the various types of fraud we encounter in our investigations and the penalties and sanctions individuals face when involved in wrongdoing affecting OPM programs.

### Health Care-Related Fraud and Abuse

OIG special agents are in regular contact with health insurance carriers participating in the Federal Employees Health Benefits Program to identify possible fraud by health care providers and subscribers. Additionally, special agents work closely with our Office of Audits when fraud issues arise during health carrier audits. They also coordinate with the OIG debarment official when investigations of health care providers reveal evidence of violations that may warrant administrative sanctions.

#### *Medical Clinic Physician Sentenced*

As referenced in our last semiannual report, a Texas physician, who owned a walk-in clinic in Midland, Texas, was found guilty in absentia on April 17, 2003, of:

- 1 count of health care fraud.
- 1 count of conspiracy to commit health care fraud.
- 1 count of aiding and abetting health care fraud.
- 46 counts of mail fraud.

On March 3, 2004, the doctor was sentenced to ten years in prison and ordered to make restitution to OPM in the amount of \$849,223. The physician fled the United States before his trial and continues to remain a fugitive. The OIG debarment official suspended the physician on February 21, 2001, shortly after his indictment. The suspension remained in effect during the pendency of the criminal case. Based on the doctor's sentencing, the debarment official is taking steps to convert the suspension to a debarment.

Disposition of the conspiracy case against the doctor's former office manager is pending. Additional information on the results of the prosecution of the former office manager will be reported in a future semiannual report.

#### *Owners of Cardiac Laboratories Charged with Health Care Fraud*

In February 2001, we received a referral from the special investigations unit at the Government Employees Hospital Association (GEHA), a health plan within the FEHBP. The allegations claimed that two cardiac laboratories submitted claims for services that were not rendered and engaged in "unbundling" of laboratory tests. *Unbundling* is the practice of billing separately for each component of a procedure that is customarily billed as a single item. This improperly increases the amount paid to the provider. An example of unbundling is to charge for each step of a procedure instead of the flat single rate for the activity.

Our three-year joint investigation with the Departments of Defense (DOD) and Health and Human Services (HHS) OIGs determined that the owners of the two cardiac laboratories, a husband and wife, had engaged in fraudulent billing schemes that included:

## Midland, Texas Physician Sentenced to 10 Years in Prison



- Billing for services not rendered.
- Up-coding (billing for more costly services than were actually performed).
- Unbundling.
- Double billing.
- Billing for unnecessary medical services not ordered by a physician.

On December 31, 2003, the two owners were indicted on 27 counts of health care fraud by a federal grand jury in Santa Ana, California. The investigators estimated that, at a minimum, 80% of the services billed by the laboratories were fraudulent. They also calculated that the government was defrauded of approximately \$1 million.

Additional information on the prosecution of these defendants will be reported in a future semiannual report.

***Physician Sentenced for Health Care Fraud***

In April 1999, we received a referral from the U.S. Attorney’s Office for the Southern District of California, alleging that a San Diego physician had performed tests that were not medically necessary and had up-coded claims. We investigated the case jointly with the Federal Bureau of Investigation (FBI) and the DOD and HHS OIGs. The investigators determined that the physician had, over a five-year period, fraudulently billed Medicare, Medicaid, FEHBP and TRICARE for surgical endoscopies not performed or up-coded diagnostic nasal endoscopies to a higher level of surgical endoscopies. (TRICARE coordinates medical benefits for military personnel, retirees, and their dependents.)

In May 2003, the physician pleaded guilty before a federal judge in San Diego, California, to one count of mail fraud.

He agreed to pay the federal government \$1 million to settle civil charges under the False Claims Act, of which \$34,520 will be reimbursed to the FEHBP. Also, as part of the civil settlement, the physician agreed to be excluded from participation in federal and state health care benefit programs.

In November 2003, the physician was sentenced to six months of incarceration and three years of supervised probation. The OIG debaring official debarred him from FEHBP for seven years, effective on the date of sentencing.

***Department of Justice Approves Additional Settlement Amount for FEHBP***

In our semiannual report for the period October 1, 2000, to March 31, 2001, we reported that ‘HCA-The Healthcare Company’ (formerly known as Columbia HCA Healthcare Corporation) had agreed in December 2000 to a \$745 million civil settlement with the Department of Justice (DOJ). The FEHBP portion of that settlement was \$5.8 million.

At the time the settlement was concluded, OPM requested DOJ to credit an additional \$2.5 million in lost investment income to the FEHBP trust fund. After reviewing this request, DOJ’s Office of Legal Counsel issued an opinion on March 12, 2004, which agreed that those funds should be reimbursed to FEHBP.

***USDA Employee Defrauds the FEHBP***

In February 2003, we received a referral from CareFirst Blue Cross and Blue Shield (CareFirst), an FEHBP-participating plan based in the Washington, D.C. area, regarding a U.S. Department of Agriculture (USDA) employee. CareFirst informed us that a high dollar amount of

**San Diego Physician Sentenced to Six Months’ Imprisonment and Agrees to \$1 Million in Civil Claims**

**\$2.5 Million in Lost Investment Income Approved for FEHBP**

## **USDA Employee Pleads Guilty to Defrauding the FEHBP**

reimbursements were paid to the USDA employee over many years for medical services rendered to his immediate family members for the same diagnosis. Working with CareFirst's special investigations unit and the OIG at the USDA, we determined that since 1995 the USDA employee received approximately \$70,000 for medical services rendered to his family living overseas.

A review of the submitted medical claim forms revealed that all family members appeared to have the same diagnosis. Usually two family members were seen by a medical provider each month, and medical notes made by the attending physician seemed to be identical for all of the family members.

After consulting with the U.S. Attorney's Office in Greenbelt, Maryland, we obtained and executed a search warrant for the federal employee's residence in July 2003. Among the evidence we seized were:

- Blank overseas medical claim forms that were partially filled out.
- Rubber stamps containing the names of medical providers that would be stamped on the claim forms.
- Medical reference books.
- Blank medical invoices from various physicians and medical establishments.

The evidence seized was found to be identical to the claim forms that the employee had previously submitted for payment.

On September 29, 2003, a federal grand jury in Greenbelt, Maryland, indicted the federal employee on four counts of mail fraud. On the same date, an arrest warrant was issued and served on him. He was released after posting bond and surrendering his passport.

The accused employee pleaded guilty to one count of mail fraud on March 25, 2004. He is scheduled to be sentenced in May 2004. The results of this prosecution will be reported in a future semiannual report.

## **Combined Federal Campaign Investigations**

Our investigators work with our auditors, OPM's CFC Operations office, and other law enforcement agencies to detect fraud or abuse in the CFC program. These investigations focus on local CFC organizations as well as Principal Combined Fund Organizations that administer the local CFCs.

### *Former Executive of the United Way of the National Capital Area Pleads Guilty to Theft of United Way Funds*

The OIG and the FBI opened a joint investigation in July 2002 of the United Way of the National Capital Area (UWNCA) due to allegations of financial irregularities. For many years, the UWNCA was the PCFO for the Washington, DC metropolitan area. During the most recent five-year period for which complete figures are available, UWNCA received an average of \$41 million in contributions annually from federal employees via the CFC.

One of the senior management officials under investigation served as the Executive Vice President of UWNCA from 1974 until his retirement in January 2001. In that position, he was the chief executive officer of the UWNCA, managing the day-to-day operations of the charity, and reporting to the UWNCA Board of Directors. On March 4, 2004, he pleaded guilty in federal court in Alexandria,



Virginia, to interstate transportation of stolen money, making false statements, and concealing facts in relation to an employee retirement plan. He admitted defrauding UWNCA during the period 1980 to 2001.

Our investigation of the executive's expense account records found that he received approximately \$70,000 in fraudulent payments from 1997 to 2001. In addition, our analysis of UWNCA's accounting records established that he was also fraudulently paid \$333,000 for unearned annual leave from 1980 to 2001.

In 1999, the former executive became eligible to retire from the UWNCA. Instead of retiring, he submitted a statement to the pension plan administrator falsely claiming that he was retiring during that year. As a result of his untruthful statement, he received more from the pension plan than he was entitled to. He actually retired in 2001.

In all, he defrauded UWNCA of \$497,279 and is obligated to make restitution of that amount to UWNCA and the pension plan as part of his plea agreement with the government. As is the case with all CFC monies, these amounts do not represent appropriated federal funds, but direct charitable donations from federal employees and other persons. He is scheduled to be sentenced in May 2004 and could receive a maximum sentence of 15 years in prison and a \$500,000 fine.

Our investigators, the FBI, and the Department of Labor's Employee Benefits Security Administration are continuing the investigation of UWNCA. Any additional prosecutions will be reported in a future semiannual report.

## Retirement Fraud and Special Investigations

### *Two Former OPM Employees and their Co-conspirators Plead Guilty to Theft*

OPM's retirement benefits specialists are responsible for processing retirement related actions for the CSRS and FERS retirement programs. These actions include new claims for federal retirement, disability, and survivor annuity benefits, as well as a broad range of retirement account maintenance services.

In early 2002, we investigated two cases involving potentially fraudulent misconduct by retirement benefits specialists. In the course of this work, we discovered schemes being used by other specialists that exploited an internal control weakness in the retirement processing system used to authorize non-recurring payment actions. As a result, we requested OPM in July 2002 to install a computer software program to detect instances where annuitants received multiple non-recurring payment actions (NRPA) authorized by the same retirement benefits specialist.

NRPA's are one-time payments made to federal annuitants or their survivors and are normally used to provide retroactive benefits or adjustments to regular annuity benefits. Examples of situations requiring such adjustments are OPM's receipt of evidence supporting additional federal service performed by a retiree, or a higher salary than was reported at the time of the retiree's separation from service.

Based on the results of this computer analysis, we identified another retirement benefits specialist who had illegally initiated NRPA's.

**Former UWNCA Official Agrees to Nearly \$500,000 in Restitution**

**OIG**  
**Investigators**  
**Determine**  
**\$3.7 Million Lost**  
**in Fraudulent**  
**Retirement**  
**Claims**

In a joint investigation with the FBI, we determined that the retirement benefits specialist had conspired with another retirement benefits specialist and several federal annuitants. Under this scheme, she authorized over one hundred fraudulent NRPA's totaling more than \$3.7 million to 33 annuitants. She had been employed by OPM for 22 years.

Both retirement benefits specialists admitted to arranging fraudulent NRPA's in exchange for kickbacks from the annuitants of half of the illegal payments. In some cases, the retirement benefits specialists placed their annuitant co-conspirators onto the Civil Service Retirement System annuity rolls, although they were not entitled to any federal retirement benefits.

A federal grand jury in Greenbelt, Maryland indicted the two retirement benefits specialists and several of the co-conspirator annuitants on January 6, 2003, for theft of government funds. Subsequently, the United States Attorney's Office also filed bribery charges against the retirement benefits specialists. The principal co-conspirator was terminated shortly after the indictments, while the other co-conspirator had already retired.

On February 27, 2004, the two former OPM employees pleaded guilty to stealing government funds and accepting bribes. On this same date, three annuitants also pleaded guilty to one count of conspiracy to defraud the United States. Subsequently, an additional four co-conspirators pleaded guilty to one count of theft of government funds. Our joint investigation continues and the results of additional prosecutions will be reported in a future semiannual report.

We have shared our findings concerning the weaknesses discovered by our on-going investigation with the OPM program office responsible for administering the retirement system. In addition, our

auditors are conducting a review of the controls for processing federal retirement payments.

***CSRS Annuitant's Son***  
***Pleads Guilty to Fraud***

In January 2001, the OIG received a referral from the U.S. Attorney's Office in Greenbelt, Maryland, alleging that an individual continued to receive his mother's annuity payments after her death in 1989. This matter arose as a *qui tam* complaint under the False Claims Act. The *qui tam* provision allows a private party, also known as a relator, to file a civil action on behalf of the United States. If the government takes over the case and recovers funds from the defendant(s), the relator may receive a portion of the proceeds. Under the treble damages provision of the Act, the relator was seeking recovery of \$692,714, representing three times \$230,905, the amount paid by OPM after the death of the survivor annuitant.

The accused did not report his mother's death to OPM until 1999, when the annuity payments ceased. According to the relator, the son also continued to file federal income tax returns to the IRS in his mother's name after her death.

On November 25, 2002, the son was indicted on six counts of theft of government funds and three counts of making false claims. Subsequently, the U.S. Attorney's office decided that the *qui tam* civil false claims complaint warranted intervention by the federal government on behalf of OPM.

The son pleaded guilty on all the counts in the indictment and was sentenced to 15 months' imprisonment, three years' supervised probation and restitution to the retirement trust fund for \$16,743 of the original \$230,905. On October 3, 2003, a federal judge in Greenbelt, Maryland, ruled in favor of the govern-

ment on the civil false claims complaint and ordered the son to pay \$692,713 to the government, of which \$213,904 will be reimbursed to the Civil Service Retirement Fund, which according to the courts, represents the amount due after the \$16,743 is paid.

### 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 OPM and the programs it administers.

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

### Retirement Fraud and Special Investigations

The Retirement and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 137 contacts, including telephone calls, letters, and referrals from other agencies. Administrative monetary recoveries pertaining to retirement fraud complaints totaled \$122,539.

**Approximately  
\$231,000  
to be  
Reimbursed  
to the  
Civil Service  
Retirement  
Fund**

**Table 2: Investigative Highlights**

**Judicial Actions:**

Arrests . . . . .	4
Indictments . . . . .	9
Convictions . . . . .	14

**Administrative Actions<sup>1</sup>:** . . . . . 0

**Judicial Recoveries:**

Fines, Penalties, Restitutions and Settlements . . . . .	\$3,370,709
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**Administrative Recoveries:**

Settlements and Restitutions . . . . .	\$122,539
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**Total Funds Recovered . . . . . \$3,493,248<sup>2</sup>**

<sup>1</sup>Includes suspensions, reprimands, demotions, resignations, removals, and reassignments.

<sup>2</sup>Includes \$497,279 representing recovery of non-federal funds to a Combined Federal Campaign agency.

### Health Care Fraud

The primary reason for establishing an OIG hotline was to handle complaints from subscribers in the Federal Employees Health Benefits Program. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP, as well as on our OIG Web site at [www.opm.gov/oig](http://www.opm.gov/oig).

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

The Health Care Fraud hotline received 369 complaints during this reporting period, including both telephone calls and letters.

### OIG-Initiated Complaints

We may initiate our own inquiries to respond effectively to allegations involv-

ing fraud, abuse, integrity issues and, occasionally, malfeasance. Our office will initiate an investigation if complaints and inquiries can be substantiated.

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 potential fraud.

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.

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.

<b>Table 3: Hotline Calls and Complaint Activity</b>	
<b>Retirement and Special Investigations Hotline and Complaint Activity:</b>	
Retained for Further Inquiry	10
Referred to:	
OIG Office of Audits	1
OPM Program Offices	80
Other Federal Agencies	46
<b>Total</b>	<b>137</b>
<b>Health Care Fraud Hotline and Complaint Activity:</b>	
Retained for Further Inquiry	117
Referred to:	
OPM Groups and Offices	38
Other Federal/State Agencies	77
FEHBP Insurance Carriers or Providers	137
<b>Total</b>	<b>369</b>
<b>Total Contacts</b>	<b>506</b>

# Index of Reporting Requirements

Inspector General Act of 1978  
(as amended)

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



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**Appendix I: Final Reports Issued with Questioned Costs  
October 1, 2003 to March 31, 2004**

	Subject	Number of Reports	Questioned Costs <sup>1</sup>	Unsupported Costs <sup>1</sup>
A.	Reports for which no management decision had been made by the beginning of the reporting period	15	\$28,352,282	\$1,293,893
B.	Reports issued during the reporting period with findings	16	55,105,062	122,564
	Subtotals (A+B)	31	83,457,344	1,416,457
C.	Reports for which a management decision was made during the reporting period:	18	62,568,879	1,416,457
	1. Disallowed costs		52,213,766	252,737
	2. Costs not disallowed		10,355,113	1,163,720
D.	Reports for which no management decision has been made by the end of the reporting period	13	20,888,465	
	Reports for which no management decision has been made within 6 months of issuance	1	2,102,899 <sup>2</sup>	

<sup>1</sup>Questioned costs represent recommendations for recovery of funds resulting from OIG audits. Unsupported costs are included in questioned costs.

<sup>2</sup>Resolution of this item has been postponed at the request of the OIG.

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**Appendix II: Final Reports Issued with Recommendations for Better Use of Funds  
October 1, 2003 to March 31, 2004**

Subject
No activity during this reporting period



**Appendix III: Insurance Audit Reports Issued  
October 1, 2003 to March 31, 2004**

Report Number	Subject	Issue Date	Questioned Costs	Unsupported Costs
1C-NM-00-03-060	<i>Health Plan of Nevada, Inc. in Las Vegas, Nevada</i>	October 16, 2003	\$	\$
1C-A7-00-02-037	<i>Health Net of Arizona, Inc. in Tucson, Arizona</i>	October 21, 2003		
1C-U4-00-03-090	<i>Health Plan of the Upper Ohio Valley in St. Clairsville, Ohio</i>	October 21, 2003		
1D-SV-00-03-076	<i>Coventry Health Care of Iowa in West Des Moines, Iowa</i>	October 27, 2003		
1A-10-60-03-020	<i>BlueCross BlueShield of Rhode Island in Providence, Rhode Island</i>	November 3, 2003	60,445	
1D-9R-00-03-093	<i>Optima Health Plan in Virginia Beach, Virginia</i>	November 3, 2003		
1C-JA-00-03-059	<i>Coventry Health Care of Louisiana in Baton Rouge and New Orleans, Louisiana</i>	November 6, 2003		
1B-40-07-02-105	<i>Mutual of Omaha Insurance Company as Underwriter for the Foreign Service Benefit Plan in Omaha, Nebraska</i>	November 24, 2003	36,977	
1C-26-00-00-018	<i>HealthAmerica Pennsylvania, Inc. in Harrisburg, Pennsylvania</i>	December 1, 2003	11,789,285	
26-00-98-015	<i>HealthAmerica Pennsylvania, Inc. in Harrisburg, Pennsylvania</i>	December 4, 2003	20,829,110	
1C-2X-00-03-036	<i>Aetna U.S. Healthcare of California, Inc. in San Ramon, California</i>	December 4, 2003	733,158	
1A-10-42-02-070	<i>BlueCross BlueShield of Kansas City in Kansas City, Missouri</i>	December 10, 2003	1,705,772	
1B-42-07-02-106	<i>Mutual of Omaha Insurance Company as Underwriter for the Association Benefit Plan in Omaha, Nebraska</i>	December 10, 2003	73,367	

**Appendix III: Insurance Audit Reports Issued (Continued)**  
**October 1, 2003 to March 31, 2004**

Report Number	Subject	Issue Date	Questioned Costs	Unsupported Costs
1B-38-07-02-104	<i>Mutual of Omaha Insurance Company as Underwriter for the Rural Carrier Benefit Plan in Omaha, Nebraska</i>	<i>December 23, 2003</i>	<i>\$ 127,176</i>	<i>\$</i>
1A-10-01-03-014	<i>Empire BlueCross BlueShield in Albany, New York</i>	<i>January 6, 2004</i>	<i>1,165,384</i>	<i>122,564</i>
1C-HA-00-02-015	<i>Kaiser Foundation Health Plan of Kansas City, Inc. in Kansas City, Missouri</i>	<i>January 6, 2004</i>	<i>574,318</i>	
1C-VX-00-02-103	<i>Prudential HealthCare HMO – Texas in San Antonio, Texas</i>	<i>January 12, 2004</i>	<i>285,346</i>	
1C-P2-00-03-074	<i>Presbyterian Health Plan in Albuquerque, New Mexico</i>	<i>January 29, 2004</i>		
1A-10-28-03-028	<i>BlueCross BlueShield of Vermont in Berlin, Vermont</i>	<i>February 2, 2004</i>	<i>42,666</i>	
1A-10-13-03-025	<i>Highmark in Camp Hill, Pennsylvania</i>	<i>February 9, 2004</i>	<i>1,169,332</i>	
1C-UB-00-02-033	<i>Prudential HealthCare HMO – Tennessee in Memphis, Tennessee</i>	<i>March 1, 2004</i>	<i>1,562,727</i>	
1A-10-39-03-004	<i>Anthem BlueCross BlueShield of Indiana in Indianapolis, Indiana</i>	<i>March 1, 2004</i>	<i>4,814,533</i>	
1C-FK-00-03-008	<i>AmeriHealth HMO, Inc. in Iselyn, New Jersey</i>	<i>March 24, 2004</i>		
1A-10-00-03-013	<i>Global Coordination of Benefits (Tier 1) for BlueCross BlueShield Plans in Washington, DC</i>	<i>March 31, 2004</i>	<i>10,135,466</i>	
<b>TOTALS</b>			<b>\$55,105,062</b>	<b>\$122,564</b>

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**Appendix IV: Internal Audit Reports Issued**  
**October 1, 2003 to March 31, 2004**

Report Number	Subject	Issue Date
4A-CA-00-02-108	<i>Office of Personnel Management's Compliance with the Federal Activities Inventory Reform Act of 1998 in Washington, DC</i>	<i>November 3, 2003</i>
4A-CF-00-03-098	<i>Office of Personnel Management's Fiscal Year 2003 Consolidated Financial Statement in Washington, DC</i>	<i>December 29, 2004</i>
4A-HR-00-03-035	<i>Office of Personnel Management's SF-52 Tracking System in Washington, DC</i>	<i>January 29, 2004</i>

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**Appendix V: Information Systems Audit Reports Issued**  
**October 1, 2003 to March 31, 2004**

Report Number	Subject	Issue Date
1A-10-41-03-026	<i>Information Systems General and Application Controls at BlueCross BlueShield of Florida in Jacksonville, Florida</i>	<i>February 3, 2004</i>

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**Appendix VI: Combined Federal Campaign Audit Reports Issued  
October 1, 2003 to March 31, 2004**

<b>Report Number</b>	<b>Subject</b>	<b>Issue Date</b>
3A-CF-00-03-049	<i>The 2000 and 2001 Combined Federal Campaigns for the Miami Valley Area in Dayton, Ohio</i>	November 3, 2003
3A-CF-00-03-042	<i>The 2000 and 2001 Combined Federal Campaigns for the Midlands Area in Columbia, South Carolina</i>	November 4, 2003
3A-CF-00-03-045	<i>The 2000 and 2001 Combined Federal Campaigns for the Rhode Island Area in Providence, Rhode Island</i>	November 4, 2003
3A-CF-00-03-044	<i>The 2000 and 2001 Combined Federal Campaigns for the New York City Area in New York, New York</i>	December 5, 2003
3A-CF-00-03-068	<i>The 1998 through 2001 Combined Federal Campaigns for Military, Veterans and Patriotic Service Organizations of America in Corte Madera, California</i>	December 24, 2003
3A-CF-00-03-043	<i>The 2000 and 2001 Combined Federal Campaigns for the Trident Area in Charleston, South Carolina</i>	January 12, 2004
3A-CF-00-03-071	<i>The 1998 through 2001 Combined Federal Campaigns for Children's Charities of America in Corte Madera, California</i>	January 29, 2004
3A-CF-00-03-082	<i>The 2000 and 2001 Combined Federal Campaigns for the Middle Georgia Area in Macon, Georgia</i>	January 29, 2004
3A-CF-00-03-039	<i>The 2001 Combined Federal Campaign for Independent Charities of America in Corte Madera, California</i>	January 29, 2004

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**Appendix VI: Combined Federal Campaign Audit Reports Issued (Continued)**  
**October 1, 2003 to March 31, 2004**

<b>Report Number</b>	<b>Subject</b>	<b>Issue Date</b>
3A-CF-00-03-070	<i>The 1998 through 2001 Combined Federal Campaigns for Health and Medical Research Charities of America in Corte Madera, California</i>	<i>February 2, 2004</i>
3A-CF-00-03-048	<i>The 2000 and 2001 Combined Federal Campaigns for the Miami-Dade County Area in Miami, Florida</i>	<i>February 11, 2004</i>
3A-CF-00-03-069	<i>The 1998 through 2001 Combined Federal Campaigns for Women, Children and Family Service Charities of America in Corte Madera, California</i>	<i>February 12, 2004</i>
3A-CF-00-03-050	<i>The 2000 and 2001 Combined Federal Campaigns for East-West Gateway in St. Louis, Missouri</i>	<i>February 18, 2004</i>
3A-CF-00-03-066	<i>The 1998 through 2001 Combined Federal Campaigns for Animal Charities of America in Corte Madera, California</i>	<i>February 24, 2004</i>
3A-CF-00-03-053	<i>The 2000 and 2001 Combined Federal Campaigns for the Hawaii-Pacific Area in Honolulu, Hawaii</i>	<i>March 1, 2004</i>
3A-CF-00-03-072	<i>The 1998 through 2001 Combined Federal Campaigns for Conservation and Preservation Charities of America in Corte Madera, California</i>	<i>March 1, 2004</i>
3A-CF-00-03-065	<i>The 1998 through 2001 Combined Federal Campaigns for Do Unto Others in Corte Madera, California</i>	<i>March 24, 2004</i>



United States  
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Office of the  
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## Report Fraud, Waste or Abuse to the Inspector General

The Director of the Office of Personnel Management and the Inspector General need your help to ensure the integrity of OPM's programs.

Please Call the *HOTLINE*:

**202-606-2423**

- Caller can remain anonymous
- Information is confidential

*You may also visit or write:*

Office of the Inspector General  
U.S. Office of Personnel Management  
1900 E Street, N.W.  
Room 6400  
Washington, DC 20415-1100

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**March 2004  
OIG-SAR-30**