

United States Office of Personnel Management
OFFICE OF THE INSPECTOR GENERAL

OCTOBER 1, 2010 – MARCH 31, 2011

Semiannual Report
TO
Congress



OFFICE OF THE INSPECTOR GENERAL



Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	\$13,733,274
Management Commitments to Recover Funds	\$60,488,358
Recoveries Through Investigative Actions	\$48,519,710

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

ACCOMPLISHMENTS:

Audit Reports Issued	29
Evaluation Reports Issued	1
Investigative Cases Closed	100
Indictments and Informations	38
Arrests	25
Convictions	32
Hotline Contacts and Complaint Activity	647
Health Care Provider Debarments and Suspensions	402
Health Care Provider Debarment and Suspension Inquiries	1,315

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In Memoriam

It is with great sadness that I report the loss of one of our staff members, Raymond Gauthier, who served this office enthusiastically as a senior Information Technology Specialist until his passing on March 24, 2011. Ray joined our staff on February 8, 2004, working in our Information Systems Technology Group supporting our servers, workstations, and applications, and helping all staff members with his signature customer service and positive attitude. Ray assisted each semiannual reporting period with extracting the statistics from our investigative tracking system and working with the staff to validate the information for reporting to Congress. Ray was a superb employee, but moreover he was a friend and colleague and we will miss him greatly.



INSPECTOR GENERAL'S MESSAGE

One of the principal responsibilities of the U.S. Office of Personnel Management (OPM) is the administration of the benefits programs for the Federal civilian employees and retirees. In this capacity, it manages and oversees the Civil Service Retirement and Disability Fund, the U.S. Postal Service (USPS) Retiree Health Benefits Fund, and the Employees Health Benefits Fund. During this reporting period, our office conducted a study of the risks and consequences of administrative and legislative proposals submitted by the USPS, Office of Inspector General (OIG) that would change the way that the USPS funds its annuities and retiree health benefits. In a series of reports issued during 2009 and 2010, the USPS OIG explained how the proposals would change the legally-mandated payments that the USPS currently makes under the Federal retirement programs and the Federal Employees Health Benefits Program.

Our study was prompted by the charge that OPM had not complied with the law and thus caused the USPS to make substantial overpayments related to its retiree benefit obligations. Consequently, OPM Director John Berry requested that our office review OPM's actions to determine if they were indeed appropriate. Our study also examined the effects that the USPS OIG's proposals would have upon the Federal benefit programs.

Between November 2010 and February 2011, when our study was released, we conducted extensive research, including close examination of the proposals, the USPS OIG reports, relevant laws, and legislative histories, as well as other public materials on the topic. We met with Congressional staff as well as OPM program offices. In particular, the OPM Actuary provided invaluable assistance to our staff as it delved into this complex topic.

The first proposal offered would change current law regarding the manner in which agencies fund the annuity benefits of employees who participate in the Federal Employees Retirement System (FERS). If an agency (here, the USPS) paid more into the Civil Service Retirement and Disability Fund than was actually needed to meet its FERS liabilities, then the proposal would allow the agency to receive a rebate or be excused from making further contributions until that surplus is exhausted. We generally agreed with this proposal, so long as it would apply equally to all Federal agencies participating in FERS and not solely to the USPS.

The second proposal would change how the USPS and the Federal Government divide responsibility for the annuities paid to former employees who worked for the USPS's predecessor, the U.S. Post Office Department (POD), and then continued to work for the USPS. These employees all participate in the Civil Service Retirement System.



All Federal annuities are calculated using both an employee's years of service as well as the salary that he or she received during his or her tenure. Under current law, for POD/USPS employees, OPM calculates the Federal Government's share as if the POD/USPS employee had retired on June 30, 1971. That is, the Federal share takes into account only the POD/USPS employee's years of service at the POD and the salary that he or she earned while working for the POD. Consequently, the Federal share of the annuity does not change, no matter how many years the employee worked at the USPS or the salary that he or she earned while there. The USPS is responsible for paying the remainder of the annuity.

The USPS OIG asserts that OPM currently has the legal and regulatory authority to change this formula and that OPM should use this authority to adopt a "years of service" approach whereby the USPS and the Federal Government would divide the responsibility for these annuities based upon the time that the employee worked for each organization. The result of this proposal would be that, in the vast majority of cases, the Federal Government's contribution to these annuities would increase.

Regardless of the merits of this proposal, our research indicated that OPM does not, in fact, have the authority to implement such a fundamental policy change. In 1974, Congress specifically legislated that the Federal Government would not be responsible for increases in annuities due to salary increases granted by the USPS. This was because as an independent entity, the USPS is not subject to budgetary or financial constraints enacted by Congress or imposed by the Executive Branch. Consequently, the Federal Government should not be responsible for the consequences of the USPS's financial decisions.

And the third proposal would change the current law requiring the USPS to fully fund both its liabilities under FERS and its obligations for future retiree health benefits. The proposal would allow the USPS to fund its FERS liabilities at an 80 percent level and its retiree health benefit obligations at a 30 percent level.

Our study determined that this proposal constitutes a dramatic departure from current law. Congress specifically designed FERS to be fully funded by participating entities, including the USPS. Such a drastic measure would affect the financial integrity of the Civil Service Retirement and Disability Fund as well as create a dangerous precedent whereby other Federal agencies could seek an exemption from the full funding requirement as well.

It is especially important that the USPS continue to fully fund its annuity and retiree health benefits because of its unstable financial situation. Permitting the USPS to continue incurring debt without setting aside the funds necessary to fulfill the promises that it has made to its employees makes it highly likely that in the future the Federal Government would have to step in and assume the USPS's financial burdens, i.e., the Taxpayer, rather than the Ratepayer, would be paying the bill.

In conclusion, we determined that OPM has complied with the law on all accounts. Furthermore, we firmly believe that the implementation of the majority of the USPS OIG proposals would have a lasting negative impact on the Federal retirement programs and trust funds.

The full text of our study can be found at www.opm.gov/oig.

Patrick E. McFarland

Inspector General



MISSION STATEMENT

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

WE ACCOMPLISH OUR MISSION BY:

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

Guiding Principles

WE ARE COMMITTED TO:

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

Strategic Objectives

THE OIG WILL:

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

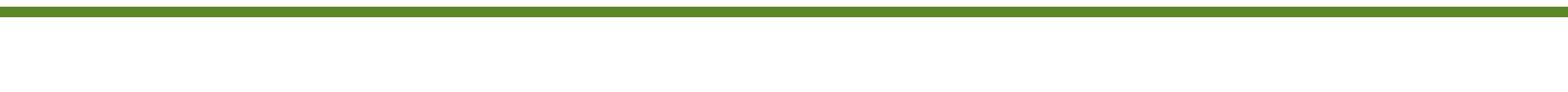




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FIELD OFFICES





AUDIT ACTIVITIES

Health Insurance Carrier Audits

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

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 260 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or health insurance plan mergers and acquisitions. The premium payments for the health insurance program are approximately \$35 billion annually.

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

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

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

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



During the current reporting period, we issued 19 final audit reports on organizations participating in the FEHBP, of which 8 contain recommendations for monetary adjustments in the amount of \$13.7 million due the OPM administered trust funds.

COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 160 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates plans charge the FEHBP are in accordance with their respective contracts and applicable Federal laws and regulations.

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

Community-rated audits focus on ensuring that:

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

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

During this reporting period, we issued 15 final audit reports on community-rated plans. These reports contain recommendations to require the health plans to return over \$8.8 million to the FEHBP.

AultCare Health Plan

CANTON, OHIO

Report No. 1C-3A-00-10-027

OCTOBER 28, 2010

AultCare Health Plan provides comprehensive medical services to its members throughout the Canton, Ohio area. This audit covered contract years 2006 through 2009. During this period, the FEHBP paid the plan approximately \$53.6 million in premiums.

Our auditors identified a total of \$3,630,341 in inappropriate health benefit charges to the FEHBP including \$1,222,168 in 2006, \$2,319,521 in 2007, and \$88,652 in 2008. The overcharges occurred because the plan did not select the correct SSSGs in 2006, 2007, and 2008 and, consequently, did not apply the largest discount to the FEHBP rates. In addition, we determined the FEHBP is due \$618,675 for investment income lost as a result of the overcharges.

Over
\$3.9 Million
of Questioned
Charges
Returned to
the FEHBP

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

AultCare Health Plan ultimately returned the entire \$3,630,341 in inappropriate health benefit charges to the FEHBP, plus a portion of the lost investment income.



PersonalCare Insurance of Illinois, Inc.

DOWNERS GROVE, ILLINOIS

Report No. 1C-GE-00-10-050

JANUARY 20, 2011

PersonalCare Insurance of Illinois, Inc. provides comprehensive medical services to its members throughout central Illinois. This audit covered contract years 2006 through 2009. During this period, the FEHBP paid the plan approximately \$47.5 million in premiums.

**Inappropriate
Charges
Amount to
Over
\$1.8 Million**

The audit identified \$1,656,505 in inappropriate health benefit charges to the FEHBP in 2008. The overcharges occurred

because the plan did not correctly identify the largest SSSG discount in 2008 and did not apply this discount to the FEHBP. The plan stated that it divided the SSSG into two sub-groups, each receiving a different rate. However, documentation shows that only one rate was charged to the SSSG, not two different rates. Therefore, the SSSG received a larger discount that should be applied to the FEHBP. In addition, we determined the FEHBP is due \$180,663 for investment income lost as a result of the overcharges.

EXPERIENCE-RATED PLANS

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

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

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

During this reporting period, we issued two experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$4.86 million in inappropriate charges to the FEHBP.

BlueCross BlueShield Service Benefit Plan

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

We issued two BCBS experience-rated final audit reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities. Our auditors identified \$4.86 million in questionable costs charged to the FEHBP contract. The BCBS Association agreed with \$3.19 million of the identified overpayments.



Global Claims Where Amounts Paid Exceeded Covered Charges for BlueCross and BlueShield Plans WASHINGTON, D.C.

Report No. 1A-99-00-10-030

JANUARY 11, 2011

We performed an audit to determine whether the BCBS plans properly charged the FEHBP for claims where the amounts paid exceeded covered charges.

Our auditors performed a computer search on the BCBS claims database, using our data warehouse function, to identify facility claims paid from January 2008 through January 2010, where the amounts paid exceeded covered charges. For this period, we identified 96,998 facility claims where the amounts paid exceeded covered charges by a total of \$135,043,267. Of these, we reviewed all facility claims where the amounts paid exceeded covered charges by \$9,500 or more, and determined whether

the BCBS plans paid these claims correctly. Our sample included 2,599 facility claims for 49 of the 63 BCBS plans.

Based on our testing, we determined that 85 of the claims in our sample were paid incorrectly, resulting

in net overcharges of \$2,216,234 to the FEHBP. Specifically, the BCBS plans overpaid 82 claims by \$2,234,710 and underpaid 3 claims by \$18,476.

The BCBS Association and/or plans agreed with \$1,655,291 and disagreed with \$560,943 of the questioned charges. The entire contested amount represents 11 claim overpayments where recovery efforts were initiated by the plans before the audit started. However, since the plans had not recovered and returned these overpayments to the FEHBP by the response due date to our draft report, we continued to question these overpayments in the final report.

**FEHBP
Overcharged
\$2.2 Million
for Facility
Claim
Payments**

WellPoint, Inc. MASON, OHIO

Report No. 1A-99-00-10-013

MARCH 17, 2011

WellPoint, Inc. includes 14 BlueCross and/or BlueShield plans in various states. Our audit of the FEHBP operations at WellPoint, Inc. covered claim payments from January 1, 2008 through December 31, 2009.

In addition, we expanded our audit scope to include inpatient facility claims with duplicate or overlapping dates of service from January 1, 2006 through September 30, 2009. During the period 2006 through 2009, WellPoint, Inc. paid approximately \$15.2 billion in FEHBP health benefit charges.

**Auditors
Question
Over
\$2.6 Million
in Claim
Overcharges**

Our auditors questioned \$2,644,595 in claim overcharges. The findings included the following:

- \$1,721,510 in duplicate claim payments;
- \$871,390 in net overpayments due to claim pricing errors; and,
- \$51,695 in net overpayments because claims were not paid in accordance with the Omnibus Budget Reconciliation Act of 1993 pricing requirements, which limit benefit payments for certain physician services provided to annuitants age 65 and older who are not covered under Medicare Part B.

Of these questioned charges, the BCBS Association and/or WellPoint, Inc. agreed with \$1,539,400 and disagreed with \$1,105,195. \$974,672 of the contested amount represents a claim overpayment where recovery efforts were initiated by WellPoint, Inc. before the audit started. However, since WellPoint, Inc. had not recovered and returned this overpayment to the FEHBP, we continued to question this amount in the final report. The



remaining contested amount represents claim overpayments that were corrected by WellPoint, Inc. after the response due date to our audit request.

EMPLOYEE ORGANIZATION PLANS

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

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

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

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

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

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

We issued no final audit reports on experience-rated comprehensive medical plans during this reporting period.



Information Systems Audits

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

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

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

Federal Information Security Management Act for FY 2010 WASHINGTON, D.C.

Report No. 4A-CI-00-10-019

NOVEMBER 10, 2010

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

Consequently, we audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's (OMB) fiscal year (FY) 2010 Reporting Instructions for the Federal Information Security Management Act and Agency Privacy Management. Our audit identified a lack of



adequate information security governance activities in accordance with legislative and regulatory requirements. Furthermore, the agency has not fully documented information security policy and procedures or established appropriate roles and responsibilities.

In FYs 2007 and 2008, we reported a material weakness in controls over the development and maintenance of OPM's IT security policies. In FY 2009, we issued a Flash Audit Alert to OPM's Director highlighting our concerns with the agency's IT security program. We also expanded the material weakness related to IT security policies to include concerns with the agency's overall information security governance and its information security management structure. Although some progress was made in FY 2010 to improve OPM's security program, we continue to consider the IT security management structure, insufficient staff, and the lack of policies and procedures to be a material weakness in OPM's IT security program.

In addition, we added a second material weakness related to the management of OPM's certification and accreditation (C&A) process. The C&A concerns were reported as a significant deficiency in the FYs 2008 and 2009 FISMA audit reports. Specifically, we noted that not all systems at OPM have an active C&A, there is a wide range of quality in the C&A packages from various program offices, and the Chief Information Officer (CIO) does not have the resources to facilitate the C&A process.

The agency has recently appointed a new Senior Agency Information Security Official. We will reevaluate this issue during the FY 2011 FISMA audit.

Information Technology Security Controls for OPM's Annuity Roll System

WASHINGTON, D.C.

Report No. 4A-CF-00-10-047

NOVEMBER 22, 2010

OPM's Annuity Roll System (ARS) is comprised of multiple sub-applications that contain detailed records of Federal annuitants, dependents, and their survivors. It is appropriate for most of the ARS applications to be grouped together as a single system because they share common hardware and software platforms and thus have similar security control requirements. However, we found that three applications should have been classified as separate OPM systems because of their unique operating environments.

These three applications have different operating platforms with unique security vulnerabilities. To properly manage these vulnerabilities, program office management must individually assess the risks involved, develop a customized and in-depth security approach tailored to each environment, and assign security responsibility to the appropriate user groups and system administrators. Without this customized approach, there is a risk that security controls will not adequately protect against the threats and vulnerabilities unique to each platform.

We continue to have concerns that the agency is not maintaining its system inventory in accordance with FISMA requirements. OPM's CIO is responsible for maintaining the agency's master system inventory; however, it relies on program offices to provide updates rather than actively monitoring the agency's system architecture to identify new systems. Also, the CIO has not reviewed existing systems for the appropriate classification of sub-applications. We considered this weakness to be a significant deficiency in OPM's overall information security program.



In addition to the concerns related to the grouping of the ARS sub-applications, we observed weaknesses in the information system security plan, the privacy impact assessment, and noted several missing controls required by the National Institute of Standards and Technology (NIST). However, the system's C&A was completed in accordance with NIST requirements, annual security controls and contingency plan testing were adequate, and the plan of action and milestones appropriately tracks all known security weaknesses.

Information Systems General and Application Controls at Coventry Health Care as Underwriter for:

Mail Handlers Benefit Plan

Foreign Service Benefit Plan

Association Benefit Plan

Rural Carrier Benefit Plan

SCOTTSDALE, ARIZONA

CRANBERRY TOWNSHIP, PENNSYLVANIA

Report No. 1B-45-00-10-017

DECEMBER 14, 2010

Our audit focused on the claims processing applications used by Coventry Health Care (Coventry) to adjudicate FEHBP claims, as well as the various processes and IT systems used to support these applications. We documented controls in place and opportunities for improvement in each of the areas below.

Security Management

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

Access Controls

We found that Coventry has implemented numerous physical controls to prevent unauthorized access to its facilities, as well as logical controls to prevent unauthorized access to its information systems. However, some physical and logical access controls for applications critical to the claims adjudication process could be improved.

Configuration Management

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

Contingency Planning

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

Application Controls

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Nothing came to our attention that caused us to believe that Coventry is not in compliance with the HIPAA security, privacy, and national provider identifier regulations.



Internal Audits

OPM INTERNAL PERFORMANCE AUDITS

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

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. KPMG LLP (KPMG) was contracted to audit the consolidated financial statements as of September 30, 2010. The contract requires that the audit be performed in accordance with GAGAS and the Office of Management and Budget (OMB) Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements include the Retirement Program (RP), Health Benefits Program (HBP), Life Insurance Program (LP), Revolving Fund (RF) Programs, and Salaries and Expenses (S&E) Fund. The RF programs provide funding for a variety of human resource-related services to other Federal agencies, such as: pre-employment testing, background investigations, and employee training. The S&E Funds provide the resources used by OPM for the administrative costs of the agency.

KPMG's responsibilities include, but are not limited to, issuing an audit report that includes:

- opinions on the consolidated financial statements and the individual statements for the three benefit programs;
- a report on internal controls; and,
- a report on compliance with certain provisions of laws and regulations.

In connection with the audit contract, we oversee KPMG's performance of the audit to ensure that it is conducted in accordance with the terms of the contract and is in compliance with GAGAS and other authoritative references.

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings, reviewing KPMG's work papers, and coordinating the issuance of audit reports. Our review disclosed that KPMG complied with GAGAS, the contract, and all other authoritative references.

In addition to the consolidated financial statements, KPMG performed the audit of the special-purpose financial statements (closing package) as of September 30, 2010 and 2009. The U.S. Department of the Treasury and the Government Accountability Office use the closing package in preparing and auditing the *Financial Report of the United States Government*.



OPM's FY 2010 Consolidated Financial Statements WASHINGTON, D.C.

Report No. 4A-CF-00-10-015
NOVEMBER 9, 2010

KPMG audited OPM's balance sheets as of September 30, 2010 and 2009 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the Retirement, Health Benefits and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2010 and 2009, and the Programs' related individual financial statements for those years. The Programs, which are essential to the payment of benefits to federal civilian employees, annuitants, and their respective dependents, operate under the following names:

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

KPMG reported that OPM's consolidated financial statements and the Programs' individual financial statements as of and for the years ended September 30, 2010 and 2009, were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. KPMG's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

An **internal control deficiency** exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.

A **significant deficiency** is a deficiency, or combination of deficiencies, in an internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

A **material weakness** is a deficiency, or combination of deficiencies, in an internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.

KPMG identified one material weakness and one significant deficiency in the internal controls that remain unresolved from prior years. The areas identified by KPMG are:

■ **Information Systems General Control Environment**

Significant deficiencies identified in previous years in both OPM's and the Programs' information systems general controls continue to persist. Specifically, security policies and procedures are not complete and do not incorporate current authoritative guidance, such as guidance on performing certification and accreditation. In addition to findings related to security management, KPMG noted

**Deficiencies
Remain in
Internal
Control Over
Financial
Reporting**



general control findings such as access control, configuration management, and segregation of duties. Although actions have been taken by OPM and the Programs' to address these weaknesses, including the appointment of a new Chief Information Officer (CIO) and Senior Agency Information Security Officer, these measures have not yet been fully executed to resolve long-standing deficiencies in OPM's security program.

Collectively, these deficiencies constitute a material weakness in OPM's internal control environment since OPM has not significantly remedied the problems noted in prior years.

■ **Financial Management and Reporting Processes of the Chief Financial Officer (CFO)**

Although improvements have been made, certain deficiencies continue to exist in the operations of the CFO's internal control over financial management and reporting, affecting the accuracy of the RF Program and S&E Fund.

Table 1 includes the significant deficiencies identified by KPMG during its audit of the financial statements for FY 2010 and 2009, respectively. OPM agreed to the findings and recommendations reported by KPMG.

Table 1: Internal Control Weaknesses

Title of Findings From FY 2010 Report	Program/Fund	FY 2010	FY 2009
Information Systems General Control Environment	All	Material Weakness	Significant Deficiency
Financial Management and Reporting Processes of the CFO	S&E and RF	Significant Deficiency	Significant Deficiency

KPMG's report on compliance with certain provisions of laws, regulations, and contracts disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards, and OMB Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

OPM's FY 2010 Special-Purpose Financial Statements WASHINGTON, D.C.

Report No. 4A-CF-00-10-016

NOVEMBER 15, 2010

The closing package financial statements, also referred to as special-purpose financial statements, are required to be audited in accordance with GAGAS and the provisions of OMB's Bulletin No. 07-04. OPM's Closing Package Financial Statements include:

- The reclassified balance sheets, the statements of net cost, the statements of changes in net position, and the accompanying notes as of September 30, 2010 and 2009;



- The Additional Note No. 30 (discloses other data necessary to make the Special-Purpose Financial Statements more informative); and
- The Trading Partner balance sheets, the statements of net cost, and the statements of changes in net position (showing the funds due between OPM and other agencies) as of September 30, 2010.

FY 2010 Closing Package Statements Receive Another Clean Opinion

KPMG reported that OPM's special-purpose financial statements are presented fairly, in all material respects.

KPMG did not identify any material weaknesses or significant deficiencies involving internal control over the financial process for the special-purpose financial statements, nor did they disclose any instances of noncompliance or other matters that are required to be reported.

OPM's Payroll Debt Management Process for Active and Separated Employees

WASHINGTON, D.C.

Report No. 4A-CF-00-10-043

MARCH 4, 2011

Our auditors conducted a performance audit of the payroll debt management process to determine if OPM is effectively managing payroll debts owed by active and separated employees.

OPM contracts with the General Services Administration (GSA) to process OPM payroll actions for active and separated employees, manage the collection of payroll debts owed by active employees, and review outstanding debt balances for possible write-off actions. OPM employees' payroll debts result from the processing of personnel actions through GSA's Comprehensive Human Resources

Integrated System, an automated tool used to document employment history, due to events such as:

- Federal Employee Health Benefits premiums paid on an employee's behalf during periods of leave without pay (LWOP) or when pay is insufficient to cover those premiums;
- Promotion adjustments due to excessive LWOP; and,
- Amended Time and Attendance due to timekeeper errors.

As of April 10, 2010, OPM had payroll debt balances for active and separated employees totaling \$596,529. Of this amount, we questioned \$32,955 in uncollected debts from separated employees. Our auditors' review of the outstanding debt balances determined that OPM lacks controls to ensure that:

- active and separated employees payroll debt is setup for collection in a timely manner;
- GSA is notifying active and separated employees of payroll debt incurred; and,
- accrued debt from intermittent employees with insufficient pay to cover health benefits premiums is monitored.

Also, we identified that OPM has ineffective controls to ensure that:

- debts from separated employees are repaid, or written off once all collection efforts have been exhausted;
- GSA reviews payroll debt for accounts that can be written off; and,
- proper records are kept for the management of employee debts.

OPM Failed to Collect \$32,955 from Separated Employees



OPM's Invoice Payment Process WASHINGTON, D.C.

Report No. 4A-CF-00-10-023

MARCH 30, 2011

We conducted a performance audit of OPM's invoice payment process in the Government Financial Information System (GFIS), which was replaced by the Consolidated Business Information System (CBIS) in October 2009. Our audit focused on identifying the reasons vendor invoices were not processed for payment by OPM program offices in GFIS, and to determine whether those invoices had subsequently been paid. Our auditors determined that 26 out of 110 invoices sampled were not paid in GFIS or CBIS.

In accordance with OPM's Financial Management Manual (FMM), the CFO, the Center for Contracting, Facilities, and Administrative Services (CFAS), and OPM's program offices are responsible for processing invoices.

Our auditors determined that prior to the implementation of CBIS, there was a lack of internal controls within the office of the CFO and program offices to monitor and track vendor invoices to ensure that they were processed and paid. We identified four areas that, if addressed, could have reduced the large number of unpaid invoices from GFIS. Specifically:

- The program offices did not have documented policies and procedures to ensure that vendor invoices were paid in accordance with the FMM.
- The CFO did not have controls in place to ensure that invoice payments were processed in accordance with FMM requirements.
- OPM's program offices, CFO, and CFAS did not communicate effectively to ensure vendor invoices were processed for payment.
- Management reports from GFIS were unreliable and did not provide enough information for program offices to determine the status of their invoices.

Review of the Payroll Functions Related to the Federal Employees Health Benefits Program Enrollment Transactions for Annuitants

WASHINGTON, D.C.

Report No. 1K-RS-00-11-034

MARCH 14, 2011

This report describes the results of our review of OPM's payroll function related to the FEHBP enrollment transactions for annuitants. We found that overall OPM has an effective program to monitor employees' health benefits transactions; however, there are some areas that need improvement. For example, we found that OPM was not resolving reconciliation discrepancies between Federal agencies' payroll office records and the participating FEHBP carriers for annuitants in a timely manner.

In addition, we identified another matter which we believe needs immediate attention. Based on our review, we believe that the Centralized Enrollment Clearinghouse system's (CLER) impact has resulted in a significant decrease in enrollment discrepancies to the point where OPM should reduce, or potentially remove, the one percent special premium rate loading for enrollment discrepancies currently offered to the FEHBP community-rated carriers. Reducing this special rate loading by even one-half would result in a savings of approximately \$34 million annually.

It should be noted that OPM's Insurance Operations (IO) is currently conducting an enrollment and premium information pilot, operating independently from CLER. By using the Enterprise Human Resources Integration data, the IO will be able to transmit premium data to carriers at the individual enrollee level every pay period. This information would eliminate the need for the one percent rate loading for community-rated plans.



Special Audits

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

DENTAL AND VISION INSURANCE PROGRAM

The Federal Employees Dental and Vision Benefits Enhancement Act of 2004 established a dental and vision benefits program for Federal employees, annuitants, and their eligible family members. OPM awarded 10 carriers with 7 year contracts to provide dental and vision insurance services for the FEDVIP.

During this reporting period, we issued one final audit report on the program for contract years 2007 and 2008.

Federal Employees Dental and Vision Insurance Program Operations as Administered by Vision Service Plan

RANCHO CORDOVA, CALIFORNIA

Report No. 1J-0A-00-10-031

JANUARY 25, 2011

In August 2006, OPM awarded a contract to the Vision Service Plan (VSP) to administer vision benefits under the FEDVIP. We tested application controls over claim benefit payments, administrative expenses, premiums, and cash management activities for contract years 2007 and 2008. In addition, we reviewed HIPAA compliance, fraud and abuse policies, quality assurance policies and procedures, and subcontracts for conformance with



the terms of the OPM contract. During contract years 2007 and 2008, benefit charges totaled \$53.2 million and premiums received totaled \$40.3 million.

We reviewed a sample of vision claims to determine whether VSP had proper application controls in place over its claims processing and check writing systems to ensure that FEDVIP transactions were valid, properly authorized, and accurately processed.

We also reviewed approximately \$1.2 million in premiums received during 2007 and 2008 to determine whether the premium costs and relative components were derived from amounts that were allowable, allocable, and reasonable. FEDVIP transactions were also traced to VSP's bank statements to ensure that they were received timely and accurately transferred into the appropriate accounts. Our review of cash management activities included an examination of bank statements to determine whether the FEDVIP funds were held and invested in an account separate from VSP's other lines of business.

Finally, we reviewed \$1.3 million in administrative expenses paid during 2007 and 2008 to determine whether the expenses were actual, necessary, reasonable, and allocable to the program. We found that VSP charged FEDVIP for unsupported administrative expenses that were not necessary or reasonable to administer benefits under the contract. VSP also charged FEDVIP for unallowable travel expenses, potential lobbying expenses, meals at its home duty station, alcoholic beverages, and gift cards.

VSP agreed with our findings and is taking corrective actions to implement our recommendations.

COMBINED FEDERAL CAMPAIGN

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

fundraising activities in Federal civilian and military workplaces worldwide.

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

CFC audits do not identify savings to the Government, because the funds involved are charitable donations made by Federal employees. Our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's CFC Operations works with the auditee to resolve the findings after the final audit report is issued.

Local CFC Audits

The local organizational structure consists of:

- ***Local Federal Coordinating Committee (LFCC)***

The LFCC is a group of Federal officials designated by the OPM Director to conduct the CFC in a particular community. It organizes the local CFC, determines the eligibility of local charities to participate, supervises the activities of the Principal Combined Fund Organization (PCFO), and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.

- ***Principal Combined Fund Organization***

The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. Their duties include collecting and distributing CFC funds, training



volunteers, and maintaining a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.

■ ***Local Federations***

A local federation is a group of local voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.

■ ***Independent Organizations***

Independent Organizations are organizations that are not members of a federation for the purposes of the CFC.

During this reporting period, we issued three final audit reports of local CFCs. Our auditors identified several violations of regulations and guidelines governing local CFC operations. Some of the types of errors we identified are:

■ ***Campaign Expenses Charged to the Incorrect Campaign Year***

Three PCFOs charged the campaigns for expenses related to other campaign years.

■ ***Expenses Not Identified as CFC-Related Charged to the Campaign***

One PCFO charged the campaign for expenses that could not be identified as belonging to the CFC.

■ ***Excess Disbursement of CFC Funds***

One PCFO disbursed an amount to charities that was in excess of the pledges received for the 2008 campaign.

■ ***Approval of PCFO Expense Reimbursement***

Two PCFOs' reimbursements for campaign expenses were not properly approved by the LFCC prior to payment.

■ ***Cut-Off Procedures for CFC Receipts***

One PCFO did not maintain proper cut-off procedures when recording CFC receipts between campaign years. As a result, the PCFO disbursed funds to member agencies that were in excess of the monies received.

■ ***Insufficient and Undocumented Allocation Methods***

The allocation methods used by one PCFO to allocate costs to the campaign were insufficient and were not supported by adequate documentation. Additionally, we identified a number of transactions which used incorrect allocation percentages or which the PCFO could not reconcile to the amount recorded in the general ledger.

We provided audit findings and recommendations for corrective action to OPM senior management. OPM notified the various CFC organizations of our recommendations and monitored for corrective actions. If the CFC organizations do not comply with the recommendations, the OPM Director can deny the organization's future participation in the CFC.



ENFORCEMENT ACTIVITIES

Investigative Cases

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

During the reporting period, our office opened 43 criminal investigations and closed 100, with 192 still in progress. Our criminal investigations led to 25 arrests, 38 indictments and informations, 32 convictions and \$48,519,710 in monetary recoveries to OPM administered trust funds. Our criminal investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$850,726,354 in criminal fines and penalties returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a complete statistical summary of our office's investigative activity, refer to the table on page 29.



HEALTH CARE FRAUD

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other Federal, state, and local law enforcement agencies. We are participating members of health care fraud task forces across the nation. Where resources permit, we also participate in DOJ and Department of Health and Human Services (HHS) sponsored Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Forces. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.

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

HEALTH CARE FRAUD CASES

Pharmaceutical Company Settles Kickback and Off-Label Promotion for \$300 Million

In February 2011, Elan Pharmaceuticals, Inc. (Elan) agreed to pay \$300 million to resolve criminal and civil liabilities arising from the illegal promotion of the epilepsy drug Zonegran.

Elan pled guilty to a misdemeanor and agreed to pay a \$97 million fine and forfeit \$3.6 million in substituted assets for the misbranding of Zonegran in violation of the Food, Drug, and Cosmetic Act (FDCA). The Food and Drug Administration (FDA) approved Zonegran for the treatment of partial seizures in epilepsy for adults over the age of 16. Once a pharmaceutical product is approved by the FDA, a manufacturer may not market or promote it for any use not specified in its new drug application. The unauthorized uses are also known as unapproved or off-label uses.

Elan promoted the sale of Zonegran for a wide variety of improper off-label uses including psychiatric disorders; migraine headaches; chronic daily headaches; eating disorders; movement disorders (e.g., Parkinson's Disease); and for a variety of seizures in children under the age of 16. Elan directed its sales force to use various aids to generate off-label sales of Zonegran. In addition, Elan's marketing efforts targeted non-epilepsy prescribers and the company paid illegal kickbacks to physicians in an effort to persuade them to prescribe Zonegran for off-label uses.

In addition to the criminal fine and forfeiture, Elan will pay \$203 million to resolve civil allegations under the False Claims Act (FCA) that it illegally promoted Zonegran and caused false claims to be submitted to Government health care programs for uses that were not medically approved and therefore not covered by those programs.



As a result of this settlement, the FEHBP received \$1,560,524.

This case was investigated by the U.S. Attorney's Office for the District of Massachusetts, the FDA, the HHS OIG, the Department of Veterans Affairs OIG, the Federal Bureau of Investigations (FBI), and the OPM OIG.

FEHBP Recovers Over \$37 Million from GlaxoSmithKline Drug Settlement

In October 2010, SB Pharmco Puerto Rico, Inc., a subsidiary of GlaxoSmithKline, PLC (GSK), agreed to pay \$750 million to resolve criminal and civil liabilities arising from knowingly selling adulterated drugs. Additionally, GSK pled guilty to charges relating to the manufacture and distribution of adulterated drugs made at GSK's now closed Cidra Puerto Rico manufacturing facility. The drugs manufactured at the Cidra Puerto Rico plant between 2001 and 2005 are Kytril, Bactroban, Paxil CR, and Avandamet.

The FDCA prohibits the introduction into interstate commerce of any drug that is adulterated. Under the FDCA, a drug is deemed adulterated if the methods, facilities, or controls used for its manufacturing, processing, packing, or holding do not conform to current good manufacturing practices to assure that the drug meets the safety requirements. The drug must meet the quality and purity characteristics which it is represented to possess.

Certain drugs produced by the company were allegedly contaminated with microorganisms, while others were processed improperly causing two-layer tablets to split with loss of therapeutic effects. It was also alleged that the plant had longstanding problems with product mix-ups, where tablets of one drug type and strength were commingled with tablets of another drug type and/or strength in the same bottle.

In addition to the criminal fine, GSK paid \$600 million to resolve civil allegations under the False Claims Act for causing false claims to be submitted to Government health care programs for certain quantities of adulterated Kytril, Bactroban, Paxil CR, and Avandamet.

As a result of this settlement, the FEHBP received a recovery of \$37,181,662.

The case was investigated by agents from the FBI; the VA OIG; the HHS OIG; the FDA Office of Criminal Investigations; the Defense Criminal Investigative Service (DCIS); and, the OPM OIG.

FEHBP Recovers \$435,567 from an Orthopaedic and Physical Therapy Center

In January 2011, the Greater Metropolitan Orthopaedic (GMO) Institute, an orthopaedic and physical therapy center located in Maryland, entered into a settlement agreement to pay the Government \$2.5 million to settle allegations under the FCA that they submitted false claims to Medicare, TRICARE, and the FEHBP by upcoding services to increase their reimbursement, and by billing the various Federal health care programs for services not rendered.

The Government alleged that between January 2004 and December 2008, GMO:

- submitted claims for office visits that either never took place or were not documented in the patient's medical records;
- billed new or existing patient visits as consultations even though a consultation was not requested and a report was not generated; and,
- submitted duplicate claims for review.

As a result of the settlement, the FEHBP received \$435,567.



This case was investigated by the U.S. Attorney's Office for the District of Maryland, the HHS OIG, the DCIS, and the OPM OIG.

Former Federal Employee Submitted Fraudulent Overseas Health Care Claims

A retired Federal employee, who received health care coverage from Blue Cross Blue Shield (BCBS), pled guilty to submitting false claims to the FEHBP. Between June 2001 and June 2009, the retiree presented the FEHBP with fraudulent invoices and statements for fictitious medical expenses that he and his wife had supposedly incurred at a hospital in Cairo, Egypt. As a result, the retiree received reimbursement checks from BCBS in the amount of \$253,727 for portions of the claimed expenses.

The OPM OIG discovered the scheme through a BCBS referral, which indicated that all of the itemized bills from the hospital and physician appeared to be identical. Furthermore, the itemized bills revealed the retiree and his wife paid in cash, using American currency, for all services rendered overseas. Our investigation determined that the hospital did not exist, and that the retiree was actually in the United States on the dates that he claimed to have received medical care in Egypt.

In January 2011, the retiree was sentenced to 23 months incarceration with 2 years supervised release, and ordered restitution of \$246,115 plus a \$10,000 fine.

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

FEHBP Recovers \$128,331 from St. Joseph Medical Center

In November 2010, St. Joseph Medical Center (SJMC), located in Towson, Maryland, agreed to pay the United States \$22 million to settle allegations, under the FCA, that it obtained unlawful remuneration under the Anti-Kickback Act. Also, SJMC violated the Stark Law by entering into a series of professional service contracts with the MidAtlantic Cardiovascular Associates (MACVA) based in Pikesville, Maryland.

This investigation developed as a result of a *qui tam* filed against SJMC. The lawsuit alleged that SJMC provided kickbacks to MACVA, under the guise of professional service agreements, in return for referrals of lucrative cardiovascular procedures. These procedures, which occurred between January 1996 and January 2006, included cardiac surgery and interventional cardiology treatments.

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

Under the settlement, SJMC also agreed to repay money it received from Federal health care programs, including the FEHBP, between January 2008 and May 2009 for medically unnecessary stents performed by a one time partner in MACVA who was later employed by SJMC.

As a result of this settlement, the FEHBP received \$128,331.

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



FEHBP Receives \$4.9 Million from Pharmaceutical Manufacturer for Off-Label and Kickback Claims

In December 2010, Kos Pharmaceuticals (Kos), a subsidiary of Abbott Laboratories, signed a settlement agreement to pay the Government \$38 million in connection with the marketing of Advicor.

Kos promoted the sale and use of Advicor as a first line therapy for management of mixed dyslipidemias (a disruption of the lipids in the blood). Such an off-label use of Advicor was not approved by the FDA, nor was it a medically accepted use covered by Federal and state Medicaid programs.

The FEHBP received a total of \$4,897,867 in the civil settlement.

This case was investigated by the HHS OIG, the VA OIG, the DCIS, various state Medicaid fraud control units, and the OPM OIG.

RETIREMENT FRAUD

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

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

RETIREMENT FRAUD CASES

Son Hides Father's Death and Collects \$452,636 in Annuity Payments

Through a computer match conducted between OPM's active annuity rolls and SSA's death records, OPM determined that a retired Federal annuitant died in June 1994. Since OPM was never notified of the annuitant's death, the annuity payments continued, resulting in an overpayment of \$452,636.

Our investigators found that the son and his father held a joint bank account in which the annuity payments were deposited. A review of the bank records determined that the son converted the funds for his own personal use. When interviewed, the son admitted to forging his father's name and using the annuity payments to pay for funeral costs, medical bills, and his own personal expenses.

The son also completed and signed an address verification form, used by OPM to verify the annuitant's vital status. The son stated that his father could not sign the form since he suffered from a stroke and Alzheimer's disease.

The son pled guilty to the theft of public money and was sentenced to 24 months incarceration, 36 months probation, ordered to pay restitution to OPM of \$452,636, and pay a \$100 fine.

This case was investigated by the U.S. Secret Service and the OPM OIG.



Daughter Opened Bank Account to Collect Deceased Father's Annuity

As a result of a computerized death match with SSA, OPM's Retirement Services office referred this case to our office for investigation. OPM was never notified of the annuitant's death and received false statements in the form of two address verification letters attesting that the annuitant was alive, when in fact he was deceased. These falsifications resulted in an overpayment of \$361,617.

Our investigators verified that the Federal annuitant died in November 1992. After his death, his wife would have been entitled to receive a survivor annuity payment. Since his death was never reported to OPM, his annuity payments continued to be issued in his name until May 2006. The Federal annuitant's wife died in February 2002. Although the wife was entitled to receive a survivor annuity payment, the annuity payments were electronically deposited into a bank account in the names of the annuitant and his daughter.

The daughter was interviewed and admitted that she was the only person with access to the bank account where the annuity payments were deposited. She further stated that she did not know that her mother was entitled to an annuity payment. Her mother did not have access, even though the account was opened while her mother was still alive. The daughter used her father's annuity payments to pay bills and living expenses. When asked why her mother's name was not added to the bank account, the daughter stated that she was the one paying bills.

OPM never received an application for survivor benefits on behalf of the annuitant's spouse. In addition, there was no evidence that the annuitant's spouse received monies from the bank account where the annuity payments were deposited.

The daughter entered a guilty plea to a charge of theft of public money. She was sentenced to 5 years probation, 180 days home confinement and 100 hours community service. Additionally, she was ordered to pay restitution to OPM for \$23,379.

Son Forged Mother's Name and Was Sentenced to 20 Months Incarceration

Through a computer match between OPM's active annuity rolls and SSA's death records, OPM determined that a survivor annuitant died in October 1999. Because OPM was never notified of the survivor annuitant's death, benefits continued, resulting in an overpayment of \$175,882.

The investigators interviewed the survivor annuitant's son who admitted to forging his mother's name on OPM documents after her death to redirect her annuity payments to the bank account of one of his friends. The son stated that he was not able to open a bank account himself, and that is why he used his friend's bank account. The son spent the annuity money for daily living expenses because he was not able to maintain steady employment. He provided the investigators with a signed written statement detailing how he submitted forged documents to OPM indicating his mother was alive in order to continue to receive his mother's annuity payments. Furthermore, the son stated that he knew it was wrong and was willing to make restitution.

The son pled guilty to theft of public money. He was sentenced to 20 months incarceration; 36 months supervised probation; and, ordered to pay full restitution of \$175,882 to OPM.

This case was investigated by the U.S. Secret Service and the OPM OIG.

Woman Assumes Deceased Sister's Identity and Steals OPM Annuity Payments

Through a computer match conducted between OPM's active annuity rolls and SSA's death records, OPM determined that a Federal survivor annuitant died in May 1984. Because OPM was never notified of the survivor annuitant's death, the annuity payments continued, resulting in an overpayment of \$292,865.



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

Our investigators interviewed the sister and she admitted spending the annuity payments and forging her deceased sister's name on OPM address verification forms creating the impression that her sister was alive to ensure the monthly annuity payments continued.

In November 2010, the sister pled guilty and was sentenced in March 2011. As part of the sentencing, she was placed on probation for 60 months and ordered to pay restitution totaling \$292,865 to OPM.

This case was investigated by the U.S. Secret Service and the OPM OIG.

Son Pleads Guilty to Theft of Public Money

As a result of a computerized death match with SSA, OPM became aware of the death of a survivor annuitant whose annuity payments continued to be deposited into a joint bank account with her son. The annuitant died in October 1990, and her unreported death resulted in an overpayment of \$334,568.

Previously, OPM sent address verification letters to the Federal survivor annuitant due to an indication that the annuitant was deceased. One of the forms was returned to OPM bearing the survivor annuitant's Social Security number and signed by her son. A note at the bottom of the page stated: "My mother is unable to sign due to Alzheimer's disease and severe arthritis."

Our investigators interviewed the survivor annuitant's son and he admitted to receiving his mother's annuity funds and converting them for his own use. He stated that he signed his mother's name on three OPM address verification forms after her death to continue the annuity payments.

The son pled guilty to theft of public money. In March 2011, he was sentenced to 6 months incarceration, 36 months probation. He was also ordered to pay a \$10,000 fine and to pay OPM \$334,568 in restitution.

This case was investigated by the U.S. Secret Service and the OPM OIG.

Son Steals Annuity and Eludes Investigators

Through a computer match conducted between OPM's active annuity rolls and SSA's death records, OPM determined that a survivor annuitant died in January 1998. Because the survivor annuitant was also a retired Federal employee, he received a Federal annuity in addition to survivor benefits. However, his death was never reported to OPM and both benefits continued to be paid, resulting in an overpayment of \$427,755.

Our investigators discovered the annuitant and his son shared a joint bank account in which the annuity payments were deposited. A review of the bank records revealed that after the annuitant's death, the son continued to receive the annuity payments and convert the funds for personal use.

When the son was served with a Federal Target of Investigation Letter issued by the U.S. Attorney's Office, he decided to flee to another state without notifying our investigators or his attorney. When our investigators ultimately discovered his location, the son was arrested. In a resulting interview, the son stated he knew it was wrong to take the money yet he used it for his personal gain.

The son pled guilty to theft of public money and in January 2011, he was sentenced to 12 months and 1 day incarceration, and 24 months supervised release. He was ordered to pay full restitution of \$427,755 to OPM.



SPECIAL INVESTIGATIONS

Our office investigates OPM employee misconduct and other wrongdoing, including allegations of fraud within OPM's personnel security and suitability program. OPM's Federal Investigative Services (FIS) conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts approximately 90 percent of all personnel background investigations for the Federal government. With a staff of over 9,300 Federal and contract employees, FIS scheduled approximately one million investigations to be processed in the first half of FY 2011. Federal agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

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

OPM Background Investigator Falsified Over Two Dozen Reports of Investigations

The OIG received an allegation from the FIS, Integrity Assurance regarding misconduct and false statements made by a former OPM background investigator.

Between March 2005 and May 2006, the background investigator falsely represented that he had interviewed a source or reviewed a record in more than two dozen background investigations Reports of Investigations.

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

On March 1, 2011, the background investigator pled guilty to making a false statement. His sentencing hearing is scheduled for June 10, 2011.

OIG HOTLINES AND COMPLAINT ACTIVITY

The OIG's Health Care Fraud Hotline, Retirement and Special Investigations Hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 647 formal complaints and telephone calls on these hotlines during the reporting period. The table on page 29 reports the activities of each hotline.

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

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

Retirement Fraud and Special Investigations Hotline

The Retirement Fraud and Special Investigations Hotline provide a method for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 303 contacts, including telephone calls, emails, letters, and referrals from other agencies.



Health Care Fraud Hotline

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

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

The Health Care Fraud Hotline received 344 complaints during this reporting period, including telephone calls, emails, and letters.

OIG-Initiated Complaints

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

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

Correction of Prior Period Semiannual Report

In our semiannual report for the period ending September 30, 2010, we over reported the amount that the FEHBP received in a civil settlement with Novartis, a pharmaceutical manufacturer. Initially, the civil settlement was processed through the Department of Justice (DOJ) for the FEHBP to receive \$6,540,763. However, in November 2010, OPM received notice from DOJ indicating an error was made by them resulting in an overpayment of \$2,166,962. Therefore, the FEHBP actually received \$4,373,801.



Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 31,461 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 402 administrative sanctions—including both suspensions and debarments—of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 1,315 sanctions-related inquiries.

We develop our sanctions caseload from a variety of sources, including:

- Administrative actions issued against health care providers by other Federal agencies;
- Cases referred by the OIG's Office of Investigations;
- Cases identified by our office through systematic research and analysis of electronically-available information about health care providers, referred to as e-debarment; and,
- Referrals from other sources, including health insurance carriers and state government regulatory and law enforcement agencies.

Sanctions serve a protective function for the FEHBP and the Federal employees who obtain, through it, their health insurance coverage. The following articles, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk, or have obtained fraudulent payment of FEHBP funds.

Debarment disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. The FEHBP administrative sanctions program establishes 18 bases for debarment. The ones we cite most frequently are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives prior notice and the opportunity to contest the sanction in an administrative proceeding.

Suspension has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.



Pennsylvania Physician and Practice Debarred After Fraud Conviction

In our semiannual report for the period ending March 2010, we reported our suspension of a Pennsylvania physician and his practice based on a referral from our Office of Investigations regarding the physician's guilty plea to health care fraud. The physician has participated in the FEHBP as a provider of medical services.

According to the sentencing documents, from January 2003 through August 2008, the physician submitted false and fraudulent claims to health care insurers for treatment and services not provided to patients and overstated the services he actually rendered to patients.

In May 2010, a judgment was entered against him. He was sentenced to 12 months and one day incarceration; supervised release for three years; \$1,083,357 in restitution; \$2,166,717 as part of a global settlement; and \$53,112 for the cost of the investigation.

The conviction constitutes a mandatory basis for debarment under FEHBP's administrative sanctions authority. We imposed a five year term of debarment based on aggravating factors associated with his offenses, including loss to the FEHBP carriers and the prolonged period during which he knowingly submitted false claims. The length of debarment includes the prior period of suspension. In addition, we debarred the doctor's medical practice based on his ownership and control, and the fact that he used it as an instrumentality through which the false claims were generated.

Texas Owner and Two Employees of Chiropractic Clinic Suspended After Indictment

Based on a referral from our Office of Investigations, we suspended an owner/operator of a chiropractic clinic, two employees of the clinic and the clinic itself in October 2010. The owner and two employees were indicted on insurance fraud. The FEHBP paid out at least \$21,189.

The indictment alleges that from January 2007 until June 2008, the owner and two employees submitted false and fraudulent insurance claims for payment to a Texas health care insurer. The defendants knew the claims contained false and misleading material. As a result, the insurer paid claims totaling approximately \$200,000 to the provider for services not rendered or not performed by a licensed professional.

Specifically, the indictment alleges that:

- The owner, who was also a county employee encouraged his co-workers to visit his clinic for "free massages" by an unlicensed massage therapist and to fill out multiple sign-in sheets for chiropractic services that were not rendered.
- The billing clerk submitted false and fraudulent claims to the health insurer for payment using the provider identification of a chiropractor who formally worked for the facility without the chiropractor's knowledge.

Because the chiropractor used his wholly-owned chiropractic facility as an instrumentality for carrying out the offenses for which he was indicted, we also suspended that facility. The suspensions are in effect for an indefinite period pending the formal entry of judgment against the provider, his employees and the clinic.



Three Detroit Area Health Care Providers Debarred from the FEHBP

In our semiannual report for the period ending September 30, 2009, we reported our suspension of five individuals from the Detroit, Michigan area, consisting of one occupational therapist, one physical therapist, and three physicians, who had been indicted as the result of an investigation conducted by a multi-agency Medicare Fraud Strike Force.

In April 2010, the U.S. District Court of Michigan sentenced three of the individuals. The occupational

therapist received one day imprisonment; three years probation; and restitution in the amount of \$1.1 million. The physical therapist received 37 months imprisonment; three years supervised release; and restitution in the amount of \$817,700. One of the physicians received 72 months imprisonment; two years supervised release; and restitution in the amount of \$3,142,194.

The convictions of the three providers above constitute a mandatory basis for debarment under the FEHBP's administrative sanctions authority. In early 2011, we debarred the occupational therapist and physical therapist, and one physician for a period of 3, 5, and 10 years, respectively.



Statistical Summary of Enforcement Activities

JUDICIAL ACTIONS:

Arrests	25
Indictments and Informations	38
Convictions	32

JUDICIAL RECOVERIES:

Restitutions and Settlements	\$48,519,710
Fines, Penalties, Assessments, and Forfeitures	\$850,726,354 ¹

RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	23
Referred to:	
OPM Program Offices	177
Other Federal Agencies	103
Total	303

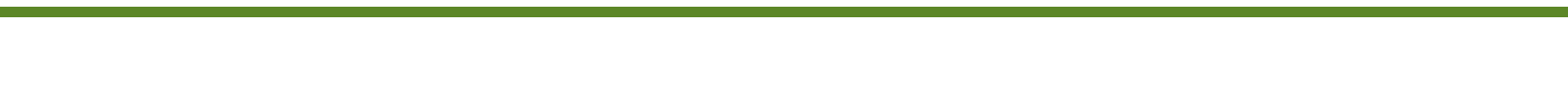
HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

Retained for Further Inquiry	67
Referred to:	
OPM Program Offices	46
Other Federal/State Agencies	55
FEHBP Insurance Carriers or Providers	176
Total	344
Total Hotline Contacts and Complaint Activity	647

ADMINISTRATIVE SANCTIONS ACTIVITY:

Debarments and Suspensions Issued	402
Health Care Provider Debarment and Suspension Inquiries	1,315
Debarments and Suspensions in Effect at End of Reporting Period	31,461

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





APPENDICES

APPENDIX I Final Reports Issued With Questioned Costs for Insurance Programs OCTOBER 1, 2010 TO MARCH 31, 2011

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	7	\$54,803,546
B. Reports issued during the reporting period with findings	8	13,733,274
Subtotals (A+B)	15	68,536,820
C. Reports for which a management decision was made during the reporting period:	10	61,588,179
1. Disallowed costs	N/A	60,448,358
2. Costs not disallowed	N/A	1,139,821
D. Reports for which no management decision has been made by the end of the reporting period	5	6,948,641
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX II – A

Final Reports Issued with Recommendations for All Other Audit Entities

OCTOBER 1, 2010 TO MARCH 31, 2011

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	0	\$ 0
B. Reports issued during the reporting period with findings	4	39,817
Subtotals (A+B)	4	39,817
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	4	39,817
E. Reports for which no management decision has been made within 6 months of issuance	0	0

APPENDIX II – B

Final Reports Issued with Recommendations for Better Use of Funds

OCTOBER 1, 2010 TO MARCH 31, 2011

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	0	\$ 0
B. Reports issued during the reporting period with findings	1	34,000,000
Subtotals (A+B)	1	34,000,000
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX III

Insurance Audit Reports Issued

OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued	Questioned Costs
1C-P2-00-10-008	Presbyterian Health Plan, Inc. in Albuquerque, New Mexico	October 15, 2010	\$ 1,154,630
1C-8G-00-10-044	Aetna Open Access – Texas in Blue Bell, Pennsylvania	October 19, 2010	0
1C-P1-00-10-045	Aetna Open Access – Texas in Blue Bell, Pennsylvania	October 19, 2010	0
1C-TE-00-10-039	ConnectiCare, Inc. in Farmington, Connecticut	October 19, 2010	0
1C-L4-00-10-040	HMO Health Ohio in Cleveland, Ohio	October 20, 2010	0
1C-3A-00-10-027	AultCare Health Plan in Canton, Ohio	October 28, 2010	4,249,016
1C-WJ-00-10-041	Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin	December 14, 2010	0
1C-J8-00-10-025	JMH Health Plan in Miami, Florida	December 15, 2010	1,137,147
1C-B9-00-10-042	United Healthcare of the Midwest, Inc. in Hartford, Connecticut	January 4, 2011	281,542
1A-99-00-10-030	Global Claims where Amounts Paid Exceeded Covered Charges for BlueCross and BlueShield Plans in Washington, D.C.	January 11, 2011	2,216,234
1C-GE-00-10-050	PersonalCare Insurance of Illinois, Inc. in Downers Grove, Illinois	January 20, 2011	1,837,168
1C-DA-00-10-060	BlueCross BlueShield of Rhode Island in Providence, Rhode Island	January 21, 2011	0
1J-0A-00-10-031	Federal Employees Dental and Vision Insurance Program Operations as Administered by Vision Service Plan in Rancho Cordova, California	January 25, 2011	0
1C-JR-00-11-006	Aetna Open Access – Northern New Jersey in Blue Bell, Pennsylvania	February 11, 2011	0
1A-99-00-10-013	WellPoint, Inc. in Mason, Ohio	March 17, 2011	2,644,595
1C-BJ-00-11-008	Coventry Health Care of Louisiana in St. Louis, Missouri	March 24, 2011	0
1C-X5-00-11-005	HealthPlus of Michigan in Flint, Michigan	March 24, 2011	0
1C-FK-00-10-058	AmeriHealth HMO, Inc. in Iselin, New Jersey	March 24, 2011	212,942
TOTALS			\$13,733,274



APPENDIX IV
Internal Audit Reports Issued
OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued
4A-RI-00-10-014	OPM's Court Ordered Benefits Branch in Washington, D.C.	October 14, 2010
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.	November 10, 2010
4A-CF-00-10-016	OPM's FY 2010 Special-Purpose Financial Statements in Washington, D.C.	November 15, 2010
4A-CF-00-10-043	OPM's Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.	March 4, 2011
4A-CF-00-10-023	OPM's Invoice Payment Process in Washington, D.C.	March 30, 2011

APPENDIX V
Combined Federal Campaign Audit Reports Issued
OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued
3A-CF-00-10-033	The 2007 and 2008 Chambersburg Area Combined Federal Campaigns in Chambersburg, Pennsylvania	January 25, 2011
3A-CF-00-10-037	The 2007 and 2008 Combined Federal Campaigns of Island County in Oak Harbor, Washington	March 4, 2011
3A-CF-00-10-035	The 2007 and 2008 Inland Northwest Combined Federal Campaigns in Spokane, Washington	March 17, 2011



APPENDIX VI

Information Systems Audit Reports Issued

OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.	November 10, 2010
4A-CF-00-10-047	Information Technology Security Controls for OPM's Annuity Roll System in Washington, D.C.	November 22, 2010
1B-45-00-10-017	Information Systems General and Application Controls at Coventry Health Care in Scottsdale, Arizona and Cranberry Township, Pennsylvania	December 14, 2010

APPENDIX VII

Evaluation Reports Issued

OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued	Funds Put to Better Use
1K-RS-00-11-034	Review of the Payroll Functions Related to the Federal Employees Health Benefits Program Enrollment Transactions for Annuitants	March 14, 2011	\$34,000,000 ²
TOTALS			\$34,000,000

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



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

OCTOBER 1, 2010 TO MARCH 31, 2011

Report Number	Subject	Date Issued
1A-10-41-03-031	BlueCross BlueShield of Florida in Jacksonville, Florida; 19 total recommendations; 3 open recommendations	May 3, 2004
4A-IS-00-05-026	Information Technology Security Controls of OPM's Electronic Questionnaire for Investigative Processing; 20 total recommendations; 1 open recommendation	June 16, 2005
4A-CI-00-06-016	Federal Information Security Management Act for FY 2006; 12 total recommendations; 1 open recommendation	September 22, 2006
4A-CI-00-07-015	The Privacy Program at OPM; 7 total recommendations; 2 open recommendations	January 25, 2007
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM; 12 total recommendations; 8 open recommendations	April 16, 2007
4A-CI-00-07-007	Federal Information Security Management Act for FY 2007; 9 total recommendations; 2 open recommendations	September 18, 2007
1A-10-41-06-054	BlueCross BlueShield of Florida in Jacksonville, Florida; 11 total recommendations; 2 open recommendations	October 12, 2007
1C-3U-00-05-085	UnitedHealthcare of Ohio, Inc., in West Chester, Ohio; 2 total recommendations; 2 open recommendations	January 18, 2008
4A-RI-00-05-037	OPM's Reclamation Process in Washington, D.C.; 10 total recommendations; 1 open recommendation	March 18, 2008
1C-G2-00-07-044	Arnett HMO Health Plan in Lafayette, Indiana; 2 total recommendations; 2 open recommendations	June 12, 2008
4A-CA-00-07-054	The Agreement between the OPM and the National Archives and Records Administration for Storage and Servicing of Records in Washington, D.C.; 8 total recommendations; 2 open recommendations	August 26, 2008
1C-6Q-00-07-029	Universal Care, Inc., of California in Signal Hill, California; 2 total recommendations; 2 open recommendations	September 15, 2008
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008; 19 total recommendations; 10 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements; 6 total recommendations; 6 open recommendations	November 14, 2008
1B-45-00-08-016	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 16 total recommendations; 10 open recommendations	March 26, 2009



APPENDIX VIII

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

OCTOBER 1, 2010 TO MARCH 31, 2011

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-09-053	Flash Audit Report – Information Technology Security Program at OPM; 4 total recommendations; 2 open recommendations	May 27, 2009
4A-CA-00-08-036	Inventory and Management of OPM's Sensitive Property; 7 total recommendations; 4 open recommendations	June 15, 2009
1A-99-00-08-065	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	June 23, 2009
1A-99-00-09-011	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 3 open recommendations	July 20, 2009
4A-CI-00-09-066	Consolidated Business Information System Implementation Project; 7 total recommendations; 7 open recommendations	September 28, 2009
1A-99-00-09-036	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 2 total recommendations; 2 open recommendations	October 14, 2009
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009; 30 total recommendations; 22 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements; 5 total recommendations; 5 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System; 8 total recommendations; 8 open recommendations	January 8, 2010
1A-10-49-09-025	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey; 24 total recommendations; 1 open recommendation	February 12, 2010
1A-99-00-09-061	Global Assistant Surgeon Claims Overpayments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 30, 2010
1A-99-00-10-009	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 4 open recommendations	March 31, 2010
1B-45-00-09-062	Coventry Health Care as Underwriter and Administrator for the Mail Handlers Benefit Plan in Rockville, Maryland; 6 total recommendations; 5 open recommendations	April 14, 2010
1A-10-85-09-023	CareFirst BlueCross BlueShield in Owings Mill, Maryland; 18 total recommendations; 3 open recommendations	May 21, 2010



APPENDIX VIII

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

OCTOBER 1, 2010 TO MARCH 31, 2011

(Continued)

Report Number	Subject	Date Issued
1A-10-41-09-063	Information Systems General and Application Controls at BlueCross BlueShield of Florida in Jacksonville, Florida; 5 total recommendations; 5 open recommendations	May 21, 2010
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 12 open recommendations	June 22, 2010
1A-99-00-09-046	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 3 open recommendations	July 19, 2010
1C-54-00-09-048	Group Health Cooperative in Seattle, Washington; 4 total recommendations; 4 open recommendations	September 8, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System; 15 total recommendations; 15 open recommendations	September 10, 2010
1C-SW-00-09-047	HealthAmerica of Pennsylvania, Inc. in Harrisburg, Pennsylvania; 3 total recommendations; 3 open recommendations	September 23, 2010
1C-Q1-00-10-026	Lovelace Health Plan in Albuquerque, New Mexico; 2 total recommendations; 2 open recommendation	September 27, 2010



APPENDIX IX

Most Recent Peer Review Results

OCTOBER 1, 2010 TO MARCH 31, 2011

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

³A rating of **Compliant or Full Compliance** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.

⁴A peer review of **Pass** is issued when the reviewing Office of Inspector General concludes that the system of quality control for the reviewed Office of Inspector General has been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. There are no deficiencies or significant deficiencies that affect the nature of the Peer Review and, therefore, the Peer Review does not contain any deficiencies or significant deficiencies.



APPENDIX X

Investigative Recoveries

OCTOBER 1, 2010 TO MARCH 31, 2011

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2004 00074	Health Care Fraud	Civil	\$ 9,036	\$ 700,000	\$ 0
I 2005 00131	Health Care Fraud	Criminal	0	58,898	0
I 2006 00047	Health Care Fraud	Criminal	51,268	1,012,809	100
I 2006 00087	Health Care Fraud	Criminal	66,899	66,899	0
I 2007 00022	Health Care Fraud	Criminal	0	1,317,179	0
I 2007 00071	Retirement Fraud	Criminal	30,932	44,240	7,900
I 2007 00073	Retirement Fraud	Criminal	35,468	35,468	600
I 2007 00073	Retirement Fraud	Criminal	35,468	35,468	600
I 2007 00079	Health Care Fraud	Criminal	9,305	65,397	0
I 2007 00079	Health Care Fraud	Criminal	0	39,000	2,000
I 2007 00113	Retirement Fraud	Criminal	23,379	23,379	0
I 2007 00116	Retirement Fraud	Civil	16,975	17,500	0
I 2008 00032	Retirement Fraud	Criminal	162,290	162,290	0
I 2008 00053	Retirement Fraud	Criminal	0	46,109	0
I 2008 00082	Retirement Fraud	Criminal	60,570	60,570	100
I 2008 00108	Health Care Fraud	Criminal	0	0	6,100
I 2008 00112	Health Care Fraud	Criminal	246,115	253,727	10,000
I 2008 00126	Health Care Fraud	Civil	4,897,867	38,159,742	0
I 2008 00140	Health Care Fraud	Criminal	19,096	36,370	0
I 2009 00033	Retirement Fraud	Criminal	25,506	25,506	300
I 2009 00046	Retirement Fraud	Criminal	36,164	36,164	100
I 2009 00088	Health Care Fraud	Criminal	486,812	21,659,085	0
I 2009 00088	Health Care Fraud	Criminal	486,812	21,659,085	0
I 2009 00106	Retirement Fraud	Criminal	1,138	1,138	1,900
I 2009 00126	Retirement Fraud	Criminal	427,755	427,755	100
I 2010 00001	Health Care Fraud	Civil	435,567	2,500,000	0
I 2010 00004	Retirement Fraud	Criminal	334,568	334,568	10,100



APPENDIX X

Investigative Recoveries

OCTOBER 1, 2010 TO MARCH 31, 2011
(Continued)

OIG Case Number ⁵	Case Category	Action ⁵	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2010 00006	Health Care Fraud	Civil	\$ 19,400	\$ 156,000	\$ 0
I 2010 00009	Retirement Fraud	Criminal	93,380	93,380	100
I 2010 00015	Retirement Fraud	Criminal	64,871	64,871	100
I 2010 00017	Retirement Fraud	Criminal	54,375	54,375	0
I 2010 00019	Retirement Fraud	Criminal	54,025	54,025	100
I 2010 00021	Retirement Fraud	Criminal	\$ 175,882	\$ 175,882	\$ 0
I 2010 00024	Health Care Fraud	Criminal	0	0	10,000,000
I 2010 00024	Health Care Fraud	Criminal	7,436,332	7,666,322	140,000,000
I 2010 00024	Health Care Fraud	Civil	29,745,329	30,665,288	600,000,000
I 2010 00031	Retirement Fraud	Criminal	95,626	95,626	100
I 2010 00040	Retirement Fraud	Criminal	95,738	95,738	100
I 2010 00044	Health Care Fraud	Criminal	0	0	3,600,000
I 2010 00044	Health Care Fraud	Criminal	0	0	97,000,000
I 2010 00044	Health Care Fraud	Civil	1,560,524	203,000,000	0
I 2010 00045	Retirement Fraud	Criminal	292,865	292,865	0
I 2010 00048	Health Care Fraud	Civil	32,589	1,279,575	0
I 2010 00050	Health Care Fraud	Criminal	0	0	100
I 2010 00054	Retirement Fraud	Criminal	34,987	34,987	100
I 2010 00061	Retirement Fraud	Criminal	59,621	59,621	-
I 2010 00063	Retirement Fraud	Criminal	452,636	452,636	100
I 2010 00065	Retirement Fraud	Criminal	43,597	43,597	654
I 2010 00070	Retirement Fraud	Criminal	105,262	105,262	85,000
I 2010 00071	Health Care Fraud	Civil	0	16,300,000	0
I 2011 00007	Health Care Fraud	Civil	128,331	22,000,000	0
I 2011 00014	Health Care Fraud	Civil	26,850	1,311,080	0
I 2011 00039	Health Care Fraud	Civil	48,500	267,896	0
GRAND TOTAL			\$48,519,710	\$373,047,372	\$850,726,354



Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

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Section 4 (a) (2):	Review of legislation and regulations.	No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies	1-25
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies.	1-16
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed.	No Activity
Section 5 (a) (4):	Matters referred to prosecutive authorities	17-25
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period.	No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period	31-35
Section 5 (a) (7):	Summary of particularly significant reports	2-25
Section 5 (a) (8):	Audit reports containing questioned costs	31-33
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds	32
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period	36-38
Section 5 (a) (11):	Significant revised management decisions during this reporting period.	No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period.	No Activity
Section 5 (a) (14) (A):	Peer reviews conducted by another OIG.	39
Section 5 (a) (16):	Peer reviews conducted by the OPM OIG	39



OIG HOTLINE

Report Fraud, Waste or Abuse to the Inspector General

Please Call the HOTLINE:

202-606-2423

Caller can remain anonymous • Information is confidential



MAILING ADDRESS:

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

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