

April 1, 2005 through
September 30, 2005



**OFFICE OF THE
INSPECTOR
GENERAL**

**Semiannual Report
to Congress**

Theodore Roosevelt
Commissioner

United States Civil Service Commission
May 13, 1889 – May 5, 1895

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

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OFFICE OF
THE INSPECTOR GENERAL

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

November 1, 2005

*Honorable Linda M. Springer
Director
U.S. Office of Personnel Management
Washington, DC 20415*

Dear Ms. Springer:

I respectfully submit the Office of the Inspector General's Semiannual Report to Congress for the period April 1, 2005 – September 30, 2005. This report describes our office's activities during the past six-month reporting period.

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

Sincerely,


*Patrick E. McFarland
Inspector General*



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The Inspector General's Message

In several prior semiannual reports, we expressed our belief that our audits and investigations of pharmacy drug benefits provided through the Federal Employees Health Benefits Program (FEHBP) would identify serious issues that need further attention. Prescription drugs represent approximately 26 percent of the total benefits paid by FEHBP plans—amounting to approximately \$6 – 7 billion each year. Further, with the overall aging of the FEHBP subscriber population, use of prescription benefits is likely to increase substantially in future years.

The results of our work in this area to date have revealed such problematic issues as illegal kickbacks, large rebates paid by pharmaceutical distributors to FEHBP health insurance carriers that were not recredited to the FEHBP, questionable business practices by administrators of pharmacy benefit plans, and improper prescription practices by physicians.

These matters touch upon all aspects of our office's work. For example, in this report, the summary of an audit of an FEHBP carrier indicates that \$1.5 million in drug rebates had not been credited to FEHBP, and over \$5 million in rebates had not been credited in a timely manner. An article in the investigations section reports a \$137.5 million civil settlement of false claims and kickback charges against a company that managed the pharmacy benefit programs of several FEHBP carriers. The FEHBP share of the settlement amounted to \$54.6 million. In addition, we have reported the debarments of two physicians who wrongfully and repeatedly prescribed an array of painkilling medications, thereby causing serious harm—including several deaths—to their patients.

We are progressively increasing the level of effort and resources that we devote to pharmaceutical-related issues, and I can assure you that we will meet the challenges posed by illegal or improper practices. We have audits underway of two of the largest pharmacy benefits management (PBM) firms associated with FEHBP carriers, and we plan to audit another sizeable PBM during the coming fiscal year.

Our investigators are currently involved with several pharmacy benefit cases presenting issues similar to the one that was settled during this reporting period. In addition, we are looking into cases that involve the practice of "off labeling" drugs. This term refers to the prescription and use of drugs for purposes other than those for which they were approved by the Food and Drug Administration.

The administrative sanctions program continues to place a high priority on debarment of health care providers who abuse drugs themselves or improperly prescribe controlled substances to patients.



THE INSPECTOR GENERAL'S MESSAGE

In a different note, I want to say a few words on the occasion of the retirement of our Assistant Inspector General for Legal Affairs, E. Jeremy Hutton, who recently retired after 39 years of federal service, the last 14 of which were as my chief legal advisor. Jerry represented the very best qualities of the career civil servant. He was highly skilled in his profession, widely knowledgeable of government operations, and absolutely dedicated to the best interests of the Office of the Inspector General. His abilities were the bedrocks on which our investigations and administrative sanctions programs have developed and achieved success. All OIG employees will miss Jerry, and we wish him the very best in his future endeavors.

Patrick E. McFarland
Inspector General



Field Offices

OFFICE OF THE
INSPECTOR GENERAL





Productivity Indicators

FINANCIAL IMPACT:

| | |
|---|--------------|
| Audit Recommendations for Recovery of Funds | \$37,157,111 |
| Recoveries Through Investigative Actions | \$57,804,793 |
| Management Commitments to Recover Funds | \$21,061,818 |

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 | 41 |
| Investigative Cases Closed. | 28 |
| Indictments | 33 |
| Convictions | 14 |
| Hotline Contacts and Complaint Activity. | 519 |
| Health Care Provider Debarments and Suspensions | 468 |
| Health Care Provider Debarment and Suspension Inquiries | 2,516 |



Audit Activities

Health and Life Insurance Carrier Audits

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

The OIG insurance audit universe contains approximately 270 audit sites, consisting of health insurance carriers, sponsors and underwriting organizations, as well as two life insurance carriers. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or plan mergers and acquisitions. The combined premium payments for the health and life insurance programs are approximately \$27 billion annually.

The health insurance plans that our office is responsible for auditing are either community-rated or experience-rated carriers.

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

Experience-rated carriers are mostly fee-for-service plans, the largest being the Blue Cross and Blue Shield health plans, but also include experience-rated HMOs.

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

During the current reporting period, we issued 20 final reports on organizations participating in the FEHBP, of which 12 contain recommendations for monetary adjustments in the aggregate amount of \$35 million due the FEHBP.

Appendix III (page 26) contains a complete listing of all health plan audit reports issued during this reporting period.

COMMUNITY-RATED PLANS

Our community-rated HMO audit universe covers approximately 160 rating areas throughout the country. Community-rated audits are designed to ensure that plans charge the appropriate premium rates in accordance with their respective contracts and applicable federal regulations.



AUDIT ACTIVITIES

FEHBP regulations require each carrier to certify that the federal government is being offered rates equivalent to the rates given to the two groups closest in subscriber size (*“similarly sized subscriber groups,”* or *SSSGs*) to the FEHBP. The rates are set by the FEHBP participating carrier, which is responsible for selecting the two appropriate groups. When our auditors determine that equivalent rates were not applied, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Therefore, our community-rated audits focus on:

- The plans’ selection and rating of appropriate SSSGs.
- The appropriateness and reasonableness of loadings charged to the FEHBP.

Loading is the cost for additional benefits purchased by a group to enhance the basic benefits package for its members.

During this reporting period, we issued 15 audit reports on community-rated plans. These reports contain recommendations to require the plans to return over \$10.5 million to the FEHBP.

Kaiser Foundation Health Plan, Inc.

**Southern California Region
Oakland, California**

Report No. 1C-62-00-04-018

SEPTEMBER 28, 2005

The Kaiser Foundation Health Plan, Inc. of the Southern California Region provides primary health care services to its members. Our audit of the plan covered contract years 2000 through 2003.

***Health Benefit
Overcharges Exceed
\$2.6 Million***

During this period, the FEHBP paid the plan approximately \$1.15 billion in premiums.

In conducting the audit, we found that the FEHBP rates were overstated by a total of \$2,676,682 due to defective pricing. In addition, we determined the FEHBP is due \$371,647 for investment income lost to the FEHBP as a result of the overcharges.

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

We found that, in each year, the plan gave a discount to a SSSG that was higher than the discount it gave the FEHBP. Our analysis showed that the most significant reason for the difference in discounts related to the plan’s use of substantially higher base rates for the FEHBP population over age 65 that is Medicare eligible than it used for a SSSG.

Independent Health Association

Buffalo, New York

Report No. 1C-QA-00-05-001

SEPTEMBER 15, 2005

Independent Health Association provides primary health care services to its members throughout western New York. Our audit of the plan covered contract years 1999 and 2002 through 2004. The FEHBP paid \$148 million in premiums to the plan during the audited periods.

The auditors found that the plan overcharged the FEHBP by \$1,062,684. The overcharges resulted primarily from excessive benefit loadings applied to the FEHBP rates. The questionable loadings included durable medical equipment (DME) and extended mental health benefits in 1999, a contraceptive benefit loading in 2002, and a combination DME/prosthetics and appliances rider for contract years 2002 through 2004.



In addition to the overcharged amount, the plan owes the FEHBP \$203,615 for lost investment income.

**Plan Returns
Over \$1.2 Million
to FEHBP**

The plan agreed with our findings and returned \$1,243,717 to the FEHBP. However, the plan still owes the FEHBP an addi-

tional \$22,582 for lost investment income for the period January 1, 2005 through June 30, 2005.

EXPERIENCE-RATED PLANS

The FEHBP offers a variety of experience-rated plans, including fee-for-service plans, which constitute the majority of federal contracts in this plan category. Several experience-rated plans are operated or sponsored by federal employee organizations.

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

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

During this reporting period, we issued three experience-rated audit reports. In these reports, our auditors recommended that the plans return \$25.4 million in inappropriate charges and lost investment income to the FEHBP.

**BLUE CROSS BLUE SHIELD
SERVICE BENEFIT PLAN**

The BlueCross BlueShield Association (BCBS Association) administers a fee-for-service plan,

which contracts with OPM on behalf of its member plans throughout the United States. Approximately 50 percent of all FEHBP subscribers are enrolled in BlueCross and BlueShield plans. The participating plans independently underwrite and process the health benefits claims of their respective federal subscribers and report their activities to the national BCBS operations center in Washington, DC.

We issued two Blue Cross and Blue Shield experience-rated reports during the reporting period. Our auditors noted \$15.2 million in questionable contract costs charged to the FEHBP including lost investment income on these questioned costs. The BCBS Association has agreed with approximately \$14.1 million.

**Global Coordination of Benefits for
BlueCross and BlueShield Plans**

Report No. 1A-10-85-04-007

JULY 27, 2005

We performed a limited-scope audit to determine whether the Blue Cross and Blue Shield plans complied with contract provisions on coordination of benefits (COB) with Medicare.

Coordination of benefits occurs when a patient has coverage under more than one health insurance plan or program. In such a case, one insurer normally pays its benefits as the primary payer and the other insurer pays a reduced benefit as the secondary payer. Medicare is usually the primary payer when the insured is also covered under an FEHBP plan.

The auditors screened the BCBS national claims database to identify claims for services rendered from October 1, 2001 through December 31, 2002 that were not coordinated with Medicare. We determined that 59 of the 62 plan sites reviewed did not



AUDIT ACTIVITIES

properly coordinate their claim charges. As a result, the FEHBP incorrectly paid as the primary insurer for these claims.

***BCBS Association
Agrees with
\$7.2 Million for
Uncoordinated
Benefit Claims***

For 96 percent of the 23,291 claims questioned, there was no information in the BCBS Association's national claims system to identify Medicare as

the primary payer when the claims were paid. However, when BCBS later added Medicare information to its system, the plans did not adjust the patients' prior claims retroactive to their Medicare effective dates. Consequently, these costs continued to be charged to the FEHBP in their entirety.

We determined that the FEHBP was overcharged \$8,045,058 for these COB errors. The BCBS Association agreed with \$7,223,365 and disagreed with \$821,694 of the questioned claim overcharges.

CareFirst BlueCross BlueShield (DC Area and Overseas Claims)

Report No. 1A-10-85-03-103

AUGUST 19, 2005

Our audit of the FEHBP operations at CareFirst BlueCross BlueShield (DC Service Area and Overseas Claims) addressed health benefit payments, miscellaneous payments and credits, administrative expenses, and cash management activities for contract years 1999 through 2002. During the audited period, the plan paid approximately \$2 billion in FEHBP claims and charged \$152 million in administrative expenses to FEHBP funds.

Our auditors determined that inappropriate charges to the FEHBP totaled \$7,087,821, as follows:

- \$3,641,915 for claims not priced in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), which limits benefit pay-

ments for certain inpatient services provided to annuitants age 65 and older who are not covered under Medicare Part A;

- \$1,762,589 for claims in the DC Service Area that were not consistent with rates agreed to in applicable provider contracts;
- \$257,148 in other claim payment errors;
- \$982,458 for unreturned audit recoveries, refunds, and vendor fees;
- \$330,679 for overstated administrative expenses; and
- \$113,032 for excessive withdrawals of FEHBP funds.

The BCBS Association agreed with \$6,850,169 of the questioned charges but disagreed with \$237,652 of the findings related to OBRA 90 claim pricing errors and unreturned refunds. Lost investment income on the questioned charges totaled \$112,250.

***Auditors Determine
\$7.1 Million Owed
the FEHBP***

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans (HMOs) 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 HMOs have the option of using a designated network of providers or using non-network providers. A member's choice in selecting one health 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 the benefits available may be less comprehensive.



Group Health Incorporated

New York, New York

Report No. 1D-80-00-04-058

JUNE 20, 2005

Group Health Incorporated (GHI) is a nonprofit health service corporation that issues hospital, basic medical, major medical, Medicare supplement, dental, and drug contracts. GHI is also a prepaid comprehensive medical plan that offers a point of service product to its subscribers. The plan's service area includes New York and the adjacent counties in northern New Jersey. Enrollment in the plan is limited to subscribers who live or work in the plan's service area.

Our audit of the FEHBP operations at GHI covered claim payments for 2000 through 2003, as well as miscellaneous health benefit payments and credits, administrative expenses, statutory reserve payments, and cash management activities for 1999 through 2003. During the period 1999 through 2003, GHI paid approximately \$959 million in FEHBP health benefit charges, \$70 million in administrative expenses, and \$11 million in state statutory reserve payments.

As a result of the audit, our auditors questioned \$9,114,560, consisting of \$9,038,049 in health benefit overcharges, \$860 in net administrative expense undercharges, and \$77,371 in statutory reserve overcharges. The most significant findings were:

- \$4,784,436 for claim payments that were not properly coordinated with Medicare;
- \$1,341,765 for unreturned uncashed health benefit checks and \$145,238 for lost investment income on uncashed checks that were either not returned to the FEHBP or not returned in a timely manner;

- \$457,579 for duplicate claim payments;
- \$329,566 for unreturned program integrity recoveries;
- \$289,993 for executive compensation overcharges; and
- \$290,853 for Disease Management Program undercharges.

In addition, during the last year, we expanded our audit scope on experience-rated plans to also include the processing of prescription drug claims and pharmacy drug rebates. On this particular audit, we reviewed pharmacy drug rebates received by GHI from 1999 through 2003. These rebates took the form of quarterly refunds on drug claims from Medco Health Solutions (formerly Merck-Medco Managed Care) and Express Scripts, which managed GHI's prescription benefits programs during the period under audit. In our review, we identified the following irregularities in GHI's handling of rebate funds:

- GHI did not return \$1,519,511 in rebates to the FEHBP.
- GHI returned over \$5 million in rebates untimely to the FEHBP during 2000 through 2003. These rebates were received by GHI in 1999 through 2003 and returned to the FEHBP from 51 to 453 days after being received.

In total, we determined that GHI owes \$9,184,480 to the FEHBP for overcharges and lost investment income. GHI agreed with \$8,120,495 of the questioned charges. Lost investment income on the questioned charges totaled \$69,920.

***GHI Owes
Over \$9 Million
to the FEHBP***



Information Systems Audits

Computer-based information systems have become increasingly important to the Office of Personnel Management as the means of carrying out its programs efficiently and accurately. We perform information systems audits of health and life insurance carriers that participate in the Federal Employees Health Benefits Program and the Federal Employees' Group Life Insurance program, and audit elements of OPM's computer security environment.

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 and eligible family members. Any breakdowns or malicious attacks (e.g., hacking, worms or viruses) affecting these federal computer based programs could compromise efficiency and effectiveness and ultimately increase the cost to the American taxpayer.

Our office examines the computer security and information systems of private health insurance carriers participating in the FEHBP by performing general and application controls audits.

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

Application controls apply to individual computer applications, such as a carrier's payroll system or benefits payment system. General controls provide a secure setting in which computer systems can operate, while application controls ensure that the systems completely and accurately process transactions.

Audit of OPM Compliance with the Federal Information Security Management Act

The Federal Information Security Management Act of 2002 (FISMA) is intended to protect information resources and assets supporting federal operations. FISMA requires agencies to implement security planning as part of the life cycle of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's inspector general.

We audited OPM's computer security programs and practices in accordance with the Office of Management and Budget's FISMA reporting instructions. Our audit of systems within OPM's program offices indicated substantial compliance with the following FISMA requirements:

OIG Identified Improvements in OPM System Security Controls

- OPM's Center for Information Services and Chief Information Officer (CIS/CIO) maintains an up-to-date inventory of agency systems and evaluates the systems annually.

OFFICE OF PERSONNEL MANAGEMENT



- CIS/CIO and program offices perform annual tests of selected systems security controls.
- Information technology (IT) contingency plans for all of the agency's major systems have been documented and tested.
- Program offices have completed system e-authentication risk assessments in accordance with OMB guidance.

We noted some opportunities for continued improvement. For example, OPM does not have a formal documented process to update IT security policies and procedures on a timely basis. In addition, program offices have not developed, documented, and tested business continuity plans for many OPM systems.

There were several elements of the agency's management of its overall IT security program that we also reviewed in accordance with OMB instructions. We found that the agency has made significant progress in the following areas since our last evaluation:

- OPM has a Plan of Action and Milestone (POA&M) process in place for managing IT security weaknesses;

- OPM has implemented a comprehensive Certification and Accreditation (C&A) process in accordance with National Institute of Science and Technology (NIST) guidance, although some system C&A packages are missing elements recommended by NIST.
- The CIS/CIO has implemented or updated configuration guides for securing OPM hardware and software resources.
- OPM followed its security incident handling policies and procedures; appropriately provided activity reports to required authorities; and informed users of security threats.
- OPM has implemented a comprehensive security awareness training program.

However, we also identified opportunities to improve or enhance information security practices. For example, several program officials indicated that security problems tracked through the POA&M process had been designated as resolved before their final resolution.

During the reporting period, we issued six reports addressing various aspects of OPM's IT security programs. Appendix V on page 28 provides a listing of these reports.



AUDIT ACTIVITIES

Internal Audits

COMBINED FEDERAL CAMPAIGN

Our office audits local organizations of the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in federal installations throughout the world. OPM is responsible, through both law and executive order, to regulate and oversee the conduct of fund-raising activities in federal civilian and military workplaces worldwide.

CFC campaigns are identified by geographical areas that may include only a single city, or encompass several cities or counties.

Our auditors review the eligibility of participating charities associated with a given campaign and the charities' compliance with federal regulations and OPM guidelines. In addition, all CFC organizations are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. As part of our audits, we review the IPA reports.

Combined Federal Campaign audits do not identify savings to the government, because the funds involved are charitable donations made by federal employees. While infrequent, our audit efforts can result in an internal referral to our OIG investigators for potential fraudulent activity.

A total of 313 local campaigns operating in the United States and overseas participated in the 2004 Combined Federal Campaign. For that year, federal employee contributions reached \$257 million, while campaign expenses totaled \$25 million.

During this reporting period we issued 10 audit reports of local CFCs and one report on national charitable federations that participated in the CFC. These reports identified numerous violations of regulations and guidelines governing local CFC operations and national federations.

LOCAL CFC AUDITS

The local organizational structure consists of:

- *Local Federal Coordinating Committee (LFCC).* The LFCC is comprised of federal employees nominated by their respective agencies. It organizes the local CFC, determines local charities' eligibility to participate, supervises the activities of the Principal Combined Fund Organization, and resolves issues relating to a local charity's noncompliance with the policies and procedures of the CFC.
- *Principal Combined Fund Organization (PCFO).* The PCFO is a charity designated by the LFCC to collect and distribute CFC charitable funds, train volunteers, and maintain a detailed accounting of CFC administrative expenses incurred during the campaign. The PCFO is reimbursed for its administrative expenses from CFC funds.
- *Local Federations.* A local federation is an association of local charitable organizations with similar objectives and interests that provides common fundraising and administrative services to its members.
- *Individual charities.*



Audit of the 2001 and 2002 Combined Federal Campaigns for Northeast Ohio

Cleveland, Ohio

Report No. 3A-CF-00-04-042

SEPTEMBER 26, 2005

United Way Services, located in Cleveland, Ohio, served as the PCFO for the 2001 and 2002 CFCs for Northeast Ohio. The campaign received pledges of \$3.7 million for both campaigns. Administrative expenses totaled approximately \$165,000 for 2001 and \$161,000 for the 2002 campaign.

Our audit identified 16 violations of CFC regulations, including:

- The PCFO charged the CFC \$3,603 in unsupported campaign expenses for the 2001 and 2002 campaigns.
- The PCFO did not maintain CFC funds in an interest-bearing account.
- The PCFO did not process all pledge cards in accordance with OPM regulations. Specifically, the PCFO made agency code changes to one pledge card from the 2001 campaign, and two pledge cards from the 2002 campaign, and had no documented authorization for the changes from the donors.
- The PCFO did not maintain CFC funds separately from United Way Services of Greater Cleveland funds.
- The PCFO submitted audited financial statements to the Local Federal Coordinating Committee/Federal Executive Board (LFCC/FEB) for campaign years 2001 and 2002 that were not prepared and audited based on the campaign periods.

- The LFCC/FEB established a three year agreement, during the 2001 campaign, with United Way Services to remain the PCFO from January 2002 through December 2004. The regulations require an annual application and selection process.
- The LFCC/FEB and PCFO did not provide any of the local agency or local federation application files for our review, stating that the files had been destroyed.
- The United Way Services of Greater Cleveland made payments from CFC funds to the Hemophilia Foundation, which was not authorized to participate in the campaign.
- The PCFO's IPA did not report all instances where the PCFO was not in compliance with CFC regulations.

*Auditors Found
16 Violations of
CFC Regulations*

NATIONAL CHARITABLE FEDERATION AUDITS

We also audit national charitable federations that participate in the CFC. National federations provide services to other charities with similar missions. Our audits of the national federations focused on the eligibility of member charities, distribution of funds and allocation of expenses.



EXTERNAL AUDIT

**SHPS, Inc. as Administrator
for Flexible Spending Account
Program for
Contract Years 2003 and 2004
Report No. 4A-RI-00-05-010
SEPTEMBER 2, 2005**

In fiscal year 2003, OPM implemented the Flexible Spending Account Program (FSAP) for approximately 1.6 million executive branch employees. The FSAP allows employees to allot pre-tax dollars for health and dependent care expenses. OPM contracted with SHPS, Inc., a benefit program administration firm in Louisville, Kentucky, to serve as the administrator for the FSAP.

During the 2003 contract year, SHPS, Inc. recorded administrative costs of approximately \$7.8 million

to start up and administer the program. In the 2004 contract year, SHPS, Inc. billed agencies approximately \$11.5 million, representing a set fee for

each employee enrolled in the FSAP. Elections for payroll deductions from participants amounted to about \$197 million during 2004.

*Auditors Identify
\$2.2 Million
in Questioned Costs
to the FSAP*

At the request of the OPM Contracting Officer, we performed an audit of SHPS, Inc., with the primary purpose of determining:

- The reasonableness, allocability and allowability of the 2003 administrative costs;
- SHPS, Inc.’s method of accounting for funds received from agencies for the 2004 contract year; and
- SHPS, Inc.’s method of accounting for funds received from payroll offices for the 2004 contract year.

Our audit identified \$2,174,204 in questioned costs for administrative expenses. The majority of the questioned costs related to unsupported allocation rates for expenses such as finance, human resources, administration, and information technology. In addition, the auditors were unable to verify whether SHPS, Inc. credited all interest earned on FSAP funds to offset program expenses.



OPM INTERNAL PERFORMANCE AUDITS

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Two critical areas of this audit activity are OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990 (CFO Act), as well as the agency's work required under the Government Performance and Results Act of 1993 (Results Act or GPRA). Our staff also conducts performance audits covering other internal OPM programs and functions.

Work/Life Programs

Report No. 4A-HR-00-03-061

SEPTEMBER 2, 2005

Work/life programs that OPM offers to its employees include family-friendly initiatives that support the use of flexible work schedules; leave programs; telework; employee assistance programs; and elder and child care services. Our audit focused on the administration of telework and child care subsidies.

The telework program gives employees the option of working at a location other than their official duty station. We determined that OPM program offices should improve controls over documentation supporting the Annual Survey Summary Report on teleworkers for OPM employees. In addition, OPM should analyze expenditures and other data related to telework to help evaluate the effectiveness of the telework program at OPM.

The child care subsidy program assists lower income employees with the cost of child care. A third party administers the program in OPM. We determined that there was no review process in place for the subsidy program and contractor invoices. We also found that, although the administrator's contract expired at the end of FY 2001, OPM has continued to use their services. Thus, there are no enforceable provisions regarding contractor performance and responsibility. To improve oversight of the child care subsidy program, OPM needs to ensure that a proper contract is put in place.

OPM management agreed with our recommendations and has taken corrective action.



Enforcement

Investigative Activities

The Office of Personnel Management administers benefits from its trust funds for all federal civilian employees and annuitants participating in the Civil Service Retirement System (CSRS), the Federal Employees Retirement System (FERS), FEHBP, and FEGLI. These programs cover over eight million current and retired federal civilian employees, including eligible family members, and disburse about \$77 billion annually. While we investigate employee misconduct and other wrongdoing, the majority of our OIG investigative efforts are spent examining potential fraud involving these trust funds.

The OIG's investigative activities produced significant results during the reporting period. We opened 79 investigations and closed 28 with 240 still in progress at the end of the period. Our investigations led to 29 arrests, 33 indictments, 14 convictions and monetary recoveries totaling \$57,804,793. For a complete statistical summary of our office's investigative activity in this reporting period, refer to the table on page 20.

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 investigations are critical to protecting federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP.

Whenever feasible, we coordinate our health care fraud investigations with the Department of Justice (DOJ) and other federal, state and local law

enforcement agencies. At the national level, we are participating members of DOJ's health care fraud working groups. We also work with U.S. Attorney's offices nationwide to focus investigative resources in areas where fraud is most common.

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

AdvancePCS

Our office, in coordination with the Department of Health and Human Services (HHS) OIG and the U.S. Attorney's office for the Eastern District of



ENFORCEMENT

Pennsylvania conducted a six-year investigation of AdvancePCS, a pharmacy benefit manager (PBM) that administered prescription drug benefits for some FEHBP plans and Medicare Plus Choice organizations. This case was resolved during the reporting period with a civil settlement in which AdvancePCS paid \$137.5 million to the federal government, of which \$54.6 million was returned to the FEHBP.

The civil settlement resolved False Claims Act and Public Contract Anti-Kickback Act violations arising from:

- Reimbursements and rebates by pharmaceutical manufacturers to AdvancePCS as improper rewards for favorable treatment of the manufacturers' drugs in AdvancePCSs' contracts with FEHBP and Medicare; and
- Payments made by AdvancePCS to health insurance plans that contracted with federally-funded health care plans to ensure that it was selected or retained as the PBM for the plans.

AdvancePCS also agreed to a consent order that requires them, for the next five years, to provide significant information to its client health plans, plan participants, doctors and pharmacists regarding its business practices. AdvancePCS will also disclose to health plans information about the payments it receives from pharmaceutical manufacturers that are in addition to rebates. Further, AdvancePCS agreed to refrain from drug switching, which increases the cost of a drug beyond what the doctor had originally prescribed.

Pharmacy Benefit Manager Agrees to \$137.5 Million Settlement

Sleep Lab Clinic

As a result of a three-year investigation, two owners of a company that set up sleep study laboratories were indicted on April 11, 2005 by a federal grand

jury in Las Vegas, Nevada on charges that they committed health care fraud and provided illegal kickbacks to physicians for patient referrals.

The joint investigation by this office, FBI, IRS, and the HHS OIG, found that the sleep lab company, headquartered in southern California, had set up sleep laboratories in ten states that had billed for unnecessary sleep studies, related tests, and excessive equipment rental charges. The indictment also charged that the owners provided illegal kickbacks and inducements to referring physicians, as well as allowing the referring physicians to bill for several unnecessary interpretative services.

Owners of Sleep Lab Clinic Indicted for Health Care Fraud and Illegal Kickbacks

This case is being prosecuted by the U.S. Attorney's office for the District of Nevada.

Cardiologist Investigated

During 2002, our agents became involved in a joint investigation with the U.S. Attorney's office in the Western District of Texas, the FBI, and the Texas Medicaid Fraud Control Unit regarding a cardiologist in West Texas. The investigation revealed that he had pleaded guilty to felony charges in June 2002. This conviction was referred to the FEHBP administrative sanctions program and the cardiologist was subsequently debarred in January 2003 from participating in the FEHBP for a three-year period. In June 2003, the Center for Medicare & Medicaid Services also excluded the cardiologist from participating in their program.

We subsequently learned that after his debarment, the cardiologist ordered his staff to create false statements to support fraudulent billings submitted to various federal health care programs, including the FEHBP. Since the debarment disqualified him from receiving FEHBP funds, he conspired with his wife, a psychiatrist, to submit claims under her



provider number and used the names of other physicians to give the appearance that services had been provided by a non-debarred provider.

The false claims resulted in hundreds of thousands of dollars in health care payments. The cardiologist also conducted unnecessary and dangerous invasive surgeries purely for illegal reimbursement purposes.

In December 2004, the cardiologist and his wife were indicted by a federal grand jury in Midland, Texas of conspiracy, health care fraud, and false statements offenses. In September 2005 the cardiologist pleaded guilty to one count of health

***Cardiologist
Sentenced to 26
Months Incarceration
and Restitution***

care fraud, one count of making false statements, and one count of conspiracy. He was sentenced to twenty-six months of incarceration, fined

\$10,000, and ordered to pay \$666,000 in restitution, of which \$134,041 will be returned to the FEHBP. Prosecution against the wife is pending.

Podiatrist Creates Fictitious Surgery Center

An investigation by our office, the HHS OIG, and the FBI revealed that a Fredericksburg, Virginia podiatrist submitted false health insurance claims to the FEHBP, Medicare, and private health insurance companies. In addition to billing for his professional services, the podiatrist submitted false outpatient facility claims from a fictitious free-standing ambulatory surgery center, when the patients were actually treated at the podiatrist's office. The total amount of the fraud against the FEHBP, Medicare, and private health insurers was \$501,736 with payments of \$272,704. The false claims submitted to the FEHBP were \$120,040, with resulting payments of \$69,054.

On May 17, 2005, the podiatrist was indicted by a federal grand jury in Richmond, Virginia. On the basis of the indictment, he was suspended from

the FEHBP effective June 2, 2005. A superseding indictment entered on June 20, 2005, added mail fraud charges and froze the podiatrist's assets for possible forfeiture.

The podiatrist signed a plea agreement on September 16, 2005, and is scheduled to enter a guilty plea on one count of Mail Fraud in federal court in Richmond, Virginia in October 2005. This case is being prosecuted by the U.S. Attorney's office for the Eastern District of Virginia.

Two Chiropractors Indicted

A joint investigation by our office, the FBI, IRS, and the North Carolina Department of Insurance established that two North Carolina chiropractors submitted false claims to health insurance companies. The chiropractors, along with others, created a clinic that provided both medical and chiropractic services. Under North Carolina law, only a medical doctor (MD) can own a medical practice.

The investigation revealed that the chiropractors hired an MD to act as the nominal owner of the clinic. However, the chiropractors themselves were the actual owners and operated the business. The clinic used the services of chiropractors and less skilled providers, such as athletic trainers and massage therapists, to perform services which were then improperly billed as physical therapy. Moreover, the claims were submitted as though the MD had furnished these services.

One of the chiropractors also owned a business which provided vascular and neurodiagnostic testing services to chiropractic patients. The diagnostic tests were interpreted by a contracted neurologist. The neurologist severed his relationship with the business, but the company continued to use the neurologist's signature stamp without his knowledge, and submitted claims to health benefits plans, including the FEHBP, under the neurologist's name. The chiropractor's business submitted more than \$360,000 in fraudulent claims as a result of the scheme.



ENFORCEMENT

This chiropractor agreed to plead guilty to bank fraud, health care fraud, and money laundering. His plea agreement calls for 24-30 months incarceration and forfeiture of \$1,065,541 in connection with the bank fraud charge; restitution in the amount of \$244,619 in connection with the healthcare fraud charge; a \$50,000 fine; and, forfeiture of his chiropractor's license. Of the \$244,619 restitution for the healthcare fraud charge, \$32,746 will be returned to the FEHBP. Sentencing is pending.

The second chiropractor was indicted on April 13, 2005 by a federal grand jury in the Western District of North Carolina. The 16-count indictment charged him with one count of conspiracy to commit bank fraud, one count of conspiracy to commit health care fraud, one count of bank fraud, six counts of mail fraud, six counts of health care fraud, and one count of conspiracy to commit money laundering. Based upon the indictment and

Indictments for Fraud, Health Care Fraud and Money Laundering

the risks to patients that were associated with the use of less qualified personnel to perform therapy services, this chiropractor and his

clinic were suspended from the FEHBP. Disposition of the criminal case is pending.

Georgia Company Falsely Billed Pre-Fabricated Orthotics as Custom-Made

In February 2005, our office received a referral from the HHS OIG, related to the investigation of a DME company located in Atlanta, Georgia. It was alleged that the company was upcoding orthotics.

Upcoding is the deliberate changing of specific treatment codes to indicate higher-priced services or products.

Our investigation with the HHS OIG and the FBI determined that the company regularly billed for standard pre-fabricated orthotics as if they were custom-made orthotics. FEHBP's losses were over \$138,000.

In June 2005, the DME company signed a civil settlement in the amount of \$900,000 with the federal government, \$74,000 of which will be returned to the FEHBP. The associated criminal issues are currently under investigation.

Company Agrees to Civil Settlement of \$900,000

RETIREMENT FRAUD

The Office of Investigations uses a variety of approaches to identify potential cases for investigation. One of our proactive initiatives is to review data to identify annuitant records with specific characteristics and anomalies that have shown, in the past, to be good indicators of retirement fraud.

We also use automated data systems available to law enforcement agencies to obtain information on annuitants that may alert us of instances where payments should no longer be made. We confirm the accuracy of the information through follow-up inquiries. Also, the Center for Retirement and Insurance Services routinely refers potential fraud cases to our office that it identifies through computer matches it conducts with the Social Security Administration. We evaluate the referrals to determine if they merit further investigation by our office. These computer matches are an effective tool in stopping payments to deceased annuitants and a good source for our criminal investigative workload.

The following case summaries are examples of our work in this area that has resulted in investigations and convictions.

Nephew Pleads Guilty in Retirement Fraud Case

We identified a Civil Service annuitant who continued to receive retirement benefits after his death in January 1992. Our investigators found that his nephew was receiving these annuity payments in his



uncle's name. In June 2004, the nephew was arrested by an OIG special agent and a U.S. Postal Inspector for theft of U.S. government funds. The nephew subsequently pleaded guilty in the U.S. District Court for the Southern District of New York. He was sentenced to five months in prison, three years of supervised probation, and was ordered to pay \$96,342 in restitution to OPM.

Daughter and Granddaughter Commit \$105,663 in Retirement Funds Fraud Over a 24 Year Period

In June 2005, the daughter and granddaughter of a Civil Service survivor annuitant both pleaded guilty in U.S. District Court for the Northern District of Florida, to a two-count indictment charging them with conspiracy to commit an offense and theft of U.S. government funds. The Department of Veterans Affairs (VA) OIG agreed to assist the OPM OIG with the investigation, since the original federal annuitant was a VA employee.

The daughter and granddaughter failed to report the survivor annuitant's death to OPM, and conspired to convert the monthly survivor annuity payments to their own use. Over a period of approximately 24 years, the defendants stole \$105,663 in annuity payments. Initially, they forged the U.S. Treasury checks made out to the survivor annuitant. Then, to receive the survivor annuity payments by direct deposit, the daughter opened a bank account in her deceased mother's name by impersonating the survivor annuitant. Both the daughter and granddaughter withdrew funds from the bank account. On two separate occasions, the daughter also forged the survivor annuitant's signature on address confirmation forms, leading OPM to believe that the survivor annuitant was alive.

Sentencing has been scheduled for October 5, 2005.

Niece Indicted on Two Counts of Theft of U.S. Government Funds

Our investigation revealed that U.S. Treasury checks and later electronic funds transfers (EFT) in the amount of \$132,186 were sent to a deceased federal annuitant from the date of her death, January 1992 until May 2003, when they were stopped by OPM.

Our investigation determined that the deceased annuitant's niece failed to notify OPM of her aunt's death and continued to illegally receive the CSRS annuity payments by forging her aunt's signature on the U.S. Treasury checks. The niece also impersonated her aunt when she requested OPM to change the annuity payments to EFT.

A federal grand jury in Los Angeles, California indicted the niece in August 2005 on two counts of theft of U.S. government funds. Her trial is scheduled to begin in November 2005.

OPM EMPLOYEE INTEGRITY

Former OPM Employee Sentenced for Theft of Retirement Funds

In several prior semiannual reports, we have described the progress of a joint investigation with the FBI, which found that two OPM retirement benefits specialists had conspired with a number of federal annuitants to misappropriate money from OPM's retirement trust fund. The six-year scheme involved payments of almost \$4 million in fraudulent federal retirement benefits.

One OPM employee was sentenced to 10 years in prison for her lead role in the scheme. Her fellow co-conspirator, a former OPM retirement benefits specialist, was sentenced in April 2005 in U.S. District Court in Maryland to five years imprisonment, three years of supervised probation and ordered to pay \$2,051,000 in restitution to the OPM Retirement Trust Fund.



ENFORCEMENT

In June 2005, the seventeenth and final defendant in the scheme was also sentenced in U.S. District Court in Maryland. She was charged with receiving stolen government funds of over \$430,000 and payment of bribes of approximately \$170,000 to the government employees. The court sentenced her to 24 months in prison, three years of supervised probation, and ordered \$430,312 in restitution to OPM.

SPECIAL INVESTIGATION

Government Nextel Accounts Compromised

In December 2004, an OPM program office alerted our office that their Nextel cell phone account was compromised. Our investigation revealed that an individual gained access to the OPM contracting officer's password and illegally purchased 20 phones, which were later sold on the streets of Baltimore, Maryland. We worked quickly with Nextel security to stop additional illegal purchases. Our investigation identified two individuals in Baltimore that were involved.

In April 2005, the men were arrested by OIG special agents and the Alexandria, Virginia Police Department. One defendant agreed to plead guilty to a minor role in the offense and cooperated with prosecutors.

Defendant Sentenced to Five Years Imprisonment and Restitution

The principal conspirator was indicted by the Commonwealth Attorney for the City of Alexandria. He was subsequently tried and found guilty. In September 2005, he was sentenced to five years imprisonment (three of which were suspended), five years of supervised probation, and restitution of \$4,400 to Nextel.

OIG HOTLINES AND COMPLAINT ACTIVITY

OIG's health care fraud hotline, retirement and special investigations hotline, and mailed-in complaints also contribute to identifying fraud and abuse. We received 519 formal complaints and calls on these hotlines during the reporting period. The table on page 20 reports the activities of each hotline.

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

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

RETIREMENT FRAUD AND SPECIAL INVESTIGATIONS HOTLINE

The Retirement and Special Investigations hotline provides a channel for reporting waste, fraud and abuse within the agency and its programs. During this reporting period, this hotline received a total of 171 contacts, including telephone calls, letters, and referrals from other agencies.



HEALTH CARE FRAUD HOTLINE

This hotline receives complaints from subscribers in the Federal Employees Health Benefits Program. The hotline number is listed in the brochures for all the health insurance plans associated with the FEHBP, as well as on our OIG Web site at www.opm.gov/oig.

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

The Health Care Fraud hotline received 348 complaints during this reporting period, including both telephone calls and letters.

OIG INITIATED COMPLAINTS

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

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

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



ENFORCEMENT

STATISTICAL SUMMARY OF INVESTIGATIONS

JUDICIAL ACTIONS:

| | |
|-------------------|----|
| Arrests | 29 |
| Indictments | 33 |
| Convictions | 14 |

JUDICIAL RECOVERIES:

| | |
|--|--------------|
| Fines, Penalties, Restitutions and Settlements | \$57,804,793 |
|--|--------------|

RETIREMENT AND SPECIAL INVESTIGATIONS HOTLINE AND COMPLAINT ACTIVITY:

| | |
|------------------------------------|-----|
| Retained for Further Inquiry | 19 |
| Referred to: | |
| OPM Program Offices | 97 |
| Other Federal Agencies | 55 |
| Total | 171 |

HEALTH CARE FRAUD HOTLINE AND COMPLAINT ACTIVITY:

| | |
|--|-----|
| Retained for Further Inquiry | 96 |
| Referred to: | |
| OPM Program Offices | 61 |
| Other Federal/State Agencies | 72 |
| FEHBP Insurance Carriers or Providers | 119 |
| Total | 348 |
| Total Hotline Contacts and Complaint Activity | 519 |



Administrative Sanctions of Health Care Providers

Under the FEHBP administrative sanctions statute, we issue suspensions and debarments of providers whose actions demonstrate that they are not presently responsible to participate in the program. At the end of the reporting period, there were 28,951 active suspensions and debarments from FEHBP.

WORKLOAD INDICATORS FOR THIS REPORTING PERIOD

- 468 debarments and suspensions of health care providers
- 2516 sanctions-related inquiries received

As noted in prior semiannual reports, we have been progressively refining our administrative sanctions caseload to focus on health care providers whose activities impact the FEHBP and its beneficiaries. This includes individuals who have submitted claims to FEHBP carriers or are members of the preferred provider networks of those carriers, or who have been the subjects of investigative interest by OIG's Office of Investigations. While this focus has resulted in lower overall levels of sanctions issued per reporting period, each sanction has greater value as a protective measure for the FEHB program and the federal employees who obtain their health insurance coverage through it.

This value is reflected in the following articles that highlight a few of the administrative sanctions cases handled by our office during the reporting period, describing enforcement actions taken against providers whose violations have placed the health or safety of enrollees at risk or have resulted in 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.

Nevada Podiatrist and Clinic Debarred for Health Care Fraud

In March 2005, a Nevada podiatrist was convicted of 67 counts of health care fraud in U.S. District Court in Las Vegas. He was sentenced to 33 months' incarceration and \$205,000 in criminal assessments and restitution.

Over a period of nearly four years, beginning in May 1999, this health care provider submitted approximately \$400,000 in fraudulent claims to



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federal health care programs, including FEHBP. These claims characterized the routine foot care services that he furnished—which are not reimbursed by most health insurance plans—as podiatric surgery, which is covered. To support the claims, he placed false, inaccurate, and misleading entries in his patients' records, indicating the existence of serious foot conditions that did not, in fact, exist.

Taking into account the large number of fraudulent claims, the prolonged time period over which the claims were submitted to health insurance carriers, and the sizeable financial losses resulting from the provider's actions, we debarred the podiatrist for five years. Further, because the provider's clinic, operating as a wholly-owned professional corporation, was used to carry out the fraudulent activities, we also debarred it for the same period.

of 40 years. In addition, he agreed to voluntarily and permanently surrender his Texas medical license.

The FEHBP administrative sanctions statute calls for mandatory debarment for no less than three years of a health care provider convicted of a crime involving patient abuse. However, because of the aggravated nature of the provider's conduct in this case, its adverse affect on the physical and mental well-being of the victims of his crimes, and the need to protect FEHBP enrollees from possible contact with him if he would begin to practice in another jurisdiction, we imposed a 10-year debarment period, effective in July 2005.

Washington State Psychiatrist Debarred After Guilty Plea to Drug Offenses

In July 2003, a psychiatrist practicing in the state of Washington pleaded guilty in U.S. District Court to a felony offense of obtaining controlled substances by misrepresentation and deception. As outlined in the statement of facts accompanying the plea, over a period of at least two years, this doctor wrote prescriptions to his patients for hydrocodone and oxycodone, with the understanding that, upon obtaining the prescribed drugs, the patients would give some of them to the psychiatrist. Through this scheme, he received hundreds of doses of these substances, which he used to satisfy, in part, his addiction to prescription medications.

The doctor was sentenced to five years' probation and restitution of \$8,600. This case was particularly appropriate for administrative sanctions action by our office because, at the time of the violations, the psychiatrist was a federal employee, and he committed his offenses in the course of treating patients at a federal health care facility.

The FEHBP sanctions statute calls for a three-year mandatory minimum debarment of health care

Texas Physician Debarred After Guilty Pleas to Sexual Assault Charges

In February 2005, a Texas physician whose practice specialized in gastroenterology and internal medicine was arrested by local police on sexual assault charges. The alleged offenses took place in connection with medical procedures during which the victims—who were female patients of this doctor—were anesthetized. The Texas State Board of Medical Examiners summarily suspended the provider's license approximately two weeks after his arrest. On the basis of the Board's action, and the fact that the doctor was a member of preferred provider networks of several FEHBP health plans, our office suspended him from participating in the FEHBP, effective February 28, 2005.

In May 2005, the doctor pleaded guilty in a Texas state court to two counts of second-degree sexual assault. He was sentenced to 180 days' incarceration, 10 years' supervised release, and total fines of \$26,000. If he should violate the terms of his release, he would be subject to incarceration for a maximum



providers who are convicted of controlled substances violations. Thus, while debarment of this physician was required by law, determination of the appropriate length of the sanction required us to consider numerous aggravating and mitigating factors.

For example, the doctor's actions represented a gross breach of professional responsibility, made all the more serious by the fact that he involved vulnerable psychiatric patients in his criminal activities. At least one of these persons herself became dependent upon the medications that she obtained for the doctor. However, the evidentiary record that we developed also revealed that the physician cooperated fully with the federal law enforcement officials investigating and prosecuting his case. The Washington Medical Quality Assurance Commission concluded that, subsequent to discovery of his offenses, the doctor complied fully with the terms of the substance abuse rehabilitation program in which he had been ordered to participate, and he was deemed fully capable of practicing medicine. Therefore, the Commission did not revoke or suspend his medical licensure.

Upon balancing these factors, we decided to impose the minimum three-year debarment period. If the doctor seeks to be reinstated to the FEHBP, he must apply to our office upon expiration of his debarment, providing evidence that establishes his responsibility to participate in the program.

Virginia Physician Debarred After State License is Suspended

In March 2005, the Virginia Board of Medicine summarily suspended the license of a physician who specialized in internal medicine, pending the outcome of a formal hearing into his prescription practices. Our office developed information that this provider, who had current or prior licenses in five states, was a member of the preferred provider networks of several FEHBP insurance plans. Therefore, we suspended him from participating in FEHBP.

In a May 2005 administrative proceeding, the Virginia Board found that the doctor had violated 26 provisions of the Virginia civil code governing medical practice. Generally, these findings involved prescription of excessive amounts of controlled substances (including the highly addictive drugs Oxycontin, morphine, Demerol, and Dilaudid), inadequate recordkeeping regarding such prescriptions, failure to conduct preliminary and followup examinations to verify patients' need for the controlled substances, and a lack of professional knowledge and training in pain management. The Board found that several patients for whom this doctor had prescribed controlled substances subsequently died of overdoses of the same types of drugs, although it did not establish that his prescriptions were the cause of death.

The Board concluded that the physician would represent a risk to his patients if he were allowed to continue practicing medicine, and extended the suspension of his license until September 2006. The regulations implementing the FEHBP administrative sanctions statute call for debarments based on revocation, suspension, or probation of professional licensure to be concurrent with the licensure action, unless serious aggravating factors affecting FEHBP or its enrollees warrant imposing an additional period. In this case, it was clear that the provider had a significant FEHBP clientele, but we could not identify factors pertaining to the FEHBP beyond those that had been addressed by the Virginia Board. Therefore, we debarred the doctor for the period during which his licensure was suspended in Virginia.



ENFORCEMENT

Index of Reporting Requirements

(Inspector General Act of 1978, As Amended)

Section 4 (a) (2): Review of legislation and regulations No Activity
Section 5 (a) (1): Significant problems, abuses, and deficiencies 1-23
Section 5 (a) (2): Recommendations regarding significant problems, abuses, and deficiencies. 1-11
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 13-18
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 25-29
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Section 5 (a) (8): Audit reports containing questioned costs 25-28
Section 5 (a) (9): Audit reports containing recommendations for better use of funds No Activity
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Section 5 (a) (11): Significant revised management decisions during this reporting period. No Activity
Section 5 (a) (12): Significant management decisions with which OIG disagreed during this reporting period No Activity



Appendices

APPENDIX I FINAL REPORTS ISSUED WITH QUESTIONED COSTS April 1, 2005 to September 30, 2005

| Subject | Number of Reports | Questioned Costs |
|--|-------------------|------------------|
| A. Reports for which no management decision had been made by the beginning of the reporting period | 16 | \$21,538,720 |
| B. Reports issued during the reporting period with findings | 13 | 37,157,111 |
| Subtotals (A+B) | 29 | 58,695,831 |
| C. Reports for which a management decision was made during the reporting period: | 15 | 22,593,871 |
| 1. Disallowed costs | | 21,061,818 |
| 2. Costs not disallowed | | 1,532,053 |
| D. Reports for which no management decision has been made by the end of the reporting period | 14 | 36,101,960 |
| Reports for which no management decision has been made within 6 months of issuance | 1 | 474,698 |

APPENDIX II FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS April 1, 2005 to September 30, 2005

No activity during this reporting period



OFFICE OF PERSONNEL MANAGEMENT

APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

April 1, 2005 to September 30, 2005

| Report Number | Audits | Issue Date | Questioned Costs |
|-----------------|---|---------------|------------------|
| 1D-80-00-04-058 | Group Health Incorporated in New York, New York | June 20, 2005 | \$9,184,480 |
| 1C-M9-00-05-054 | MVP Health Plan in Schenectady, New York Proposed Rate Reconciliation | June 27, 2005 | 209,515 |
| 1C-TE-00-05-062 | ConnectiCare, Inc. in Farmington, Connecticut Proposed Rate Reconciliation | June 30, 2005 | |
| 1C-JV-00-05-057 | Fallon Community Health Plan in Worcester, Massachusetts Proposed Rate Reconciliation | July 13, 2005 | |
| 1D-M5-00-05-020 | California Care in Woodland Hill, California | July 14, 2005 | 96,883 |
| 1C-P2-00-05-060 | Presbyterian Health Plan in Albuquerque, New Mexico Proposed Rate Reconciliation | July 24, 2005 | |
| 1C-51-00-05-053 | Health Insurance Plan of Greater New York in New York, New York Proposed Rate Reconciliation | July 24, 2005 | 285,637 |
| 1C-MK-00-05-058 | Blue Choice of New York in Rochester, New York Proposed Rate Reconciliation | July 25, 2005 | 414,184 |
| 1A-10-85-04-007 | Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C. | July 27, 2005 | 8,045,058 |
| 1C-DA-00-05-061 | BlueChip Coordinated Health Partners, Inc. in Providence, Rhode Island Proposed Rate Reconciliation | July 29, 2005 | |



APPENDIX III

INSURANCE AUDIT REPORTS ISSUED

April 1, 2005 to September 30, 2005

(Continued)

| Report Number | Audits | Issue Date | Questioned Costs |
|-----------------|--|--------------------|---------------------|
| 1B-32-00-02-110 | National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia | August 1, 2005 | \$ |
| 1C-WD-00-05-056 | Dean Health Plan, Inc. in Madison, Wisconsin Proposed Rate Reconciliation | August 5, 2005 | 3,292,280 |
| 1C-BJ-00-05-066 | Coventry Health Care of Louisiana in Bethesda, Maryland Proposed Rate Reconciliation | August 11, 2005 | |
| 1C-MM-00-05-055 | Group Health Plan in Earth City, Missouri Proposed Rate Reconciliation | August 12, 2005 | |
| 1A-10-85-03-103 | CareFirst BlueCross and Blue Shield (DC Service Area and Overseas Claims) in Owings Mills, Maryland | August 19, 2005 | 7,200,071 |
| 1C-EB-00-05-003 | HMOBlue in Syracuse, New York | September 15, 2005 | 534,889 |
| 1C-QA-00-05-001 | Independent Health Association in Buffalo, New York | September 15, 2005 | 1,266,299 |
| 1C-65-00-03-085 | Kaiser Foundation Health Plan of Colorado and Kaiser Foundation Health Plan of Kansas City in Aurora, Colorado | September 21, 2005 | 1,405,282 |
| 1C-52-00-04-085 | Health Alliance Plan in Detroit, Michigan | September 28, 2005 | |
| 1C-62-00-04-018 | Kaiser Foundation Health Plan, Inc., Southern California Region in Oakland, California | September 28, 2005 | 3,048,329 |
| TOTALS | | | \$34,982,907 |



OFFICE OF PERSONNEL MANAGEMENT

APPENDIX IV

INTERNAL AUDIT REPORTS ISSUED

April 1, 2005 to September 30, 2005

| Report Number | Subject | Issue Date | Questioned Costs |
|-----------------|--|-------------------|--------------------|
| 4A-RI-00-05-047 | Retirement System Modernization Acquisition | April 27, 2005 | \$ |
| 4A-CA-00-03-108 | Procurement Process at the Office of Personnel Management | May 9, 2005 | |
| 4A-RI-00-05-010 | SHPS, Inc. as Administrator for the Federal Flexible Spending Account Program for Contract Years 2003 and 2004 | September 2, 2005 | 2,174,204 |
| 4A-HR-00-03-061 | Work/Life Programs | September 9, 2005 | |
| TOTALS | | | \$2,174,204 |

APPENDIX V

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

April 1, 2005 to September 30, 2005

| Report Number | Subject | Issue Date |
|-----------------|--|--------------------|
| 4A-OD-00-05-013 | Information Technology Security Controls of the Enterprise Human Resource Integration | May 9, 2005 |
| 4A-OD-00-05-024 | Information Technology Security Controls of USAJOBS | May 26, 2005 |
| 4A-IS-00-05-026 | Information Technology Security Controls of the Electronic Questionnaire for Investigative Processing | June 16, 2005 |
| 4A-CF-00-05-025 | Information Technology Security Controls of the Personnel Investigation Processing System Financial Interface System | June 22, 2005 |
| 4A-CI-00-05-014 | Federal Information Security Management Act Audit | September 29, 2005 |
| 4A-CI-00-05-064 | Federal Information Security Management Act Fiscal Year 2005 Follow-Up Audit | September 29, 2005 |



APPENDIX VI

COMBINED FEDERAL CAMPAIGN AUDIT REPORTS ISSUED

April 1, 2005 to September 30, 2005

| Report Number | Subject | Issue Date |
|----------------------|---|--------------------|
| 3A-CF-00-04-056 | The 2001 and 2002 Combined Federal Campaign Activities for the Global Impact Federation in Alexandria, Virginia | April 11, 2005 |
| 3A-CF-00-03-056 | The 2000 and 2001 Combined Federal Campaigns for Metropolitan Atlanta in Atlanta, Georgia | May 6, 2005 |
| 3A-CF-00-03-011 | The 2001 Combined Federal Campaign for the National Capital Area in Washington, D.C. | May 9, 2005 |
| 3A-CF-00-04-048 | The 2002 Combined Federal Campaign for the Fort Riley Area in Junction City, Kansas | May 20, 2005 |
| 3A-CF-00-04-039 | The 2002 Combined Federal Campaign for the Fort Polk Area in Fort Polk, Louisiana | May 26, 2005 |
| 3A-CF-00-04-054 | The 2001 and 2002 Combined Federal Campaigns for South Central Alaska in Anchorage, Alaska | August 1, 2005 |
| 3A-CF-00-04-051 | The 2001 and 2002 Combined Federal Campaigns for the Greater Chattanooga Area in Chattanooga, Tennessee | August 1, 2005 |
| 3A-CF-00-04-041 | The 2001 and 2002 Combined Federal Campaigns for Southeastern North Carolina in Bragg, North Carolina | September 15, 2005 |
| 3A-CF-00-04-050 | The 2001 and 2002 Combined Federal Campaigns for the Denver Metropolitan Area in Denver, Colorado | September 22, 2005 |
| 3A-CF-00-04-042 | The 2001 and 2002 Combined Federal Campaigns for the Northeast Ohio Area in Cleveland, Ohio | September 26, 2005 |
| 3A-CF-00-04-053 | The 2001 and 2002 Combined Federal Campaigns for the Heartland Area in Kansas City, Missouri | September 28, 2005 |

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