



UNITED STATES  
OFFICE OF PERSONNEL MANAGEMENT



Office of the Inspector General

**SEMIANNUAL REPORT  
TO CONGRESS**

October 1, 2012 – March 31, 2013

OFFICE OF THE INSPECTOR GENERAL



# Productivity Indicators

## FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds . . . . .	\$12,002,032
Management Commitments to Recover Funds . . . . .	\$13,378,790
Recoveries Through Investigative Actions . . . . .	\$15,343,149

*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 . . . . .	33
Evaluation Reports Issued . . . . .	1
Investigative Cases Closed . . . . .	47
Indictments and Informations . . . . .	21
Arrests . . . . .	20
Convictions . . . . .	15
Hotline Contacts and Preliminary Inquiries Complaints . . . . .	1,133
Health Care Provider Debarments and Suspensions . . . . .	392
Health Care Provider Debarment and Suspension Inquiries . . . . .	3,123

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# INSPECTOR GENERAL'S MESSAGE

In September 2012, we brought to former Director John Berry's attention the fact that the U.S. Office of Personnel Management (OPM) lacked an adequate Suspension and Debarment program, for any of its programs or contracting activities, other than with regard to health care providers participating in the Federal Employees Health Benefits Program (FEHBP).<sup>1</sup> OPM was not exercising its authority to suspend or debar individuals and/or companies pursuant to the Federal Acquisition Regulation (FAR) at Title 48 CFR Part 9.4 (which covers procurements), nor using the Government-wide Non-Procurement Debarment and Suspension Common rule in any cases unrelated to the FEHBP. Actions under these rules have Government-wide reciprocal effect, meaning that if an individual or company is suspended or debarred from doing business with one Federal agency, it is also suspended or debarred from doing business with other Federal agencies.

We are particularly concerned about OPM's inability to take suspension or debarment actions with respect to the background investigations program administered by OPM's Federal Investigative Services (FIS). FIS provides investigative products and services for over 100 Federal agencies to use as the basis for suitability and security clearance determinations. Since 2007, as a result of criminal investigations conducted by our office, 17 background investigators have been criminally convicted of falsifying background investigation reports. While FIS took prompt administrative action, such as terminating Federal employees and removing contractors from OPM contracts upon substantiation of misconduct or lack of integrity, that action alone was not equivalent to a Government-wide suspension or debarment. It did not prevent these individuals from being employed by, or doing business with, other Federal agencies. In fact, we learned of a contract background investigator removed from the OPM contract for falsifying reports, who obtained contract employment performing background investigations for another Federal agency while a criminal indictment was pending.

I am pleased to report that former Director Berry instructed a group of contracting experts to develop a suspension and debarment program for OPM. Staff from my office worked closely with this group, and OPM also reached out to the Office of Management and Budget and the Interagency Suspension and Debarment Committee for assistance in establishing policies and procedures. OPM Contracting Policy 9.4, which establishes OPM's FAR Suspension and Debarment program, became effective on March 20, 2013. OPM is currently working on gaining approval to suspend and debar individuals pursuant to the Government-wide Non-procurement Debarment and Suspension Common Rule. Meanwhile, my office is preparing referrals for the new suspension and debarment program.

  
Patrick E. McFarland  
*Inspector General*

<sup>1</sup>Under a delegation from successive OPM Directors, the Office of the Inspector General has conducted an administrative sanctions program with respect to such health care providers since 1993.







# 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 Office of the Inspector General 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 230 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 over \$45 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 25 final audit reports on organizations participating in the FEHBP, of which 12 contain recommendations for monetary adjustments in the amount of \$12 million due the OPM administered trust funds.



## COMMUNITY-RATED PLANS

The community-rated HMO audit universe covers approximately 120 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 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 Federal annuitants.*

*Many Federal annuitants may also be enrolled in Medicare. Therefore, the FEHBP rates may be adjusted to account for the coordination of benefits with Medicare.*

During this reporting period, we issued 12 final audit reports on community-rated plans. These reports contain recommendations that require the health plans to return over \$1.8 million to the FEHBP. Summaries of two reports are provided below to highlight notable audit findings.

### **PacifiCare of Texas, Inc.**

CYPRESS, CALIFORNIA

Report No. 1C-GF-00-12-030

NOVEMBER 1, 2012

PacifiCare of Texas, Inc. (Plan) provides comprehensive medical services to its members in the San Antonio, Texas area. This audit covered contract years 2009 through 2011. During this period, the FEHBP paid the Plan approximately \$56.6 million in premiums.

We identified \$604,829 in inappropriate health benefit charges to the FEHBP in 2009 through 2011. In addition, we determined the FEHBP is due \$23,030 for investment income lost as a result of the overcharges.

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

The overcharges occurred because the Plan inappropriately charged the FEHBP a 1.17 percent assessment related to the Texas Health Insurance Pool (THIP) in contract years 2009 through 2011. Furthermore, the Plan erroneously paid two FEHBP claims without proper Coordination of Benefits (COB) with Medicare in contract year 2011.

**Inappropriate Charges Amount to \$604,829**

*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 Plan acknowledged that the THIP charges were incorrectly applied to the FEHBP in 2009 through 2011. However, the Plan contends that it processed the two FEHBP claims based on the information it had at the time and therefore were processed appropriately.

## Coventry Health Care, Inc.

COLUMBIA, MARYLAND

Report No. 1C-IG-00-12-049

FEBRUARY 21, 2013

Coventry Health Care, Inc. (Plan) provides comprehensive medical services to its members throughout the state of Maryland. This audit covered contract years 2007 through 2011.

During this period, the FEHBP paid the Plan approximately \$23.7 million in premiums.

**Inappropriate  
Charges Amount  
to \$553,610**

We identified \$553,610 in inappropriate health benefit charges to the FEHBP in contract years 2007 through 2009. The overcharges occurred because the Plan did not apply the largest SSSG discount to the FEHBP rates. In addition, the Plan made inappropriate adjustments to the FEHBP's rate development, resulting in 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 carriers' claims processing, financial and cost accounting systems; and,
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued nine experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$10.1 million in inappropriate charges and lost investment income to the FEHBP.

## BlueCross BlueShield Service Benefit Plan

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act, enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for Federal employees, annuitants, and dependents. The BlueCross BlueShield Association (Association), on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a Government-wide Service Benefit Plan with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP) Director's Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, BCBS plans, and OPM. The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims, maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

The 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 BCBS operations center in Washington, D.C. Approximately 62 percent of all FEHBP subscribers are enrolled in BCBS plans.





We issued seven BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, and/or cash management activities. Our auditors identified \$7.2 million in questionable costs charged to the FEHBP contract. The BCBS agreed with \$4.4 million of the identified overcharges. Summaries of two final reports are provided below to highlight our notable audit findings.

### Global Assistant Surgeon Claim Overpayments for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. IA-99-00-12-055

FEBRUARY 21, 2013

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to assistant surgeon claim payments, which should be paid in accordance with the BCBS plans' pricing procedures.

**FEHBP  
Overcharged  
\$1.1 Million for  
Assistant Surgeon  
Claims**

Using our SAS data warehouse function, we performed a computer search on the BCBS claims database to identify claims paid from August 2009 through May 2012 that potentially were not paid in accordance with the BCBS plans' assistant surgeon pricing procedures.

We determined that 59 of the 64 BCBS plans incorrectly paid 1,217 assistant surgeon claim lines. Specifically, the BCBS plans overpaid 1,124 claim lines by \$1,137,440 and underpaid 93 claim lines by \$80,114. This resulted in net overcharges of \$1,057,326 to the FEHBP. Most of these claim payment overcharges were due to manual processing errors and/or resulted from the BCBS plans using incorrect procedure allowances when processing the claims.

The Association and/or BCBS plans agreed with \$881,150 of the questioned net overcharges.

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

WASHINGTON, D.C.

Report No. IA-99-00-12-029

MARCH 20, 2013

We performed a limited scope performance audit to determine whether the BCBS plans complied with contract provisions relative to COB with Medicare.

Using our SAS data warehouse function, we performed a computer search on the BCBS claims database to identify payments for services incurred on or after May 15, 2011, paid from June 2011 through March 2012, and potentially not coordinated with Medicare. We determined that 59 of the 64 BCBS plans did not properly coordinate claim charges with Medicare. As a result, the FEHBP incorrectly paid 10,771 claim lines when Medicare was the primary insurer.

Our audit disclosed the following for these COB errors:

- For 51 percent of the claim lines questioned, the BCBS plans incorrectly paid these claims due to retroactive adjustments. Specifically, no information existed in the BCBS national claims system to identify Medicare as the primary payer when the claims were paid. However, even after the Medicare information was added to the claims system, the BCBS plans did not adjust the patients' prior claims retroactively to the Medicare effective dates. Consequently, these costs continued to be charged entirely to the FEHBP;
- For 38 percent of the claim lines questioned, the BCBS plans incorrectly paid these claims due to manual or systematic processing errors; and,
- For the remaining 11 percent of the claim lines questioned, the BCBS plans incorrectly paid these claims due to provider billing errors.

**FEHBP  
Overcharged  
\$4.7 Million for  
Claim Payment  
Errors**



We determined that the FEHBP was overcharged \$4,393,785 for these COB errors. In addition to these COB errors, we identified 725 claim line payments that contained other types of claim payment errors, resulting in overcharges of \$296,854 to the FEHBP. In total, we determined that the BCBS plans incorrectly paid 11,496 claim lines, resulting in overcharges of \$4,690,639 to the FEHBP. The Association and/or BCBS plans agreed with \$2,478,834 of these questioned claim overcharges.

## 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, Inc.; National Association of Letter Carriers; National Postal Mail Handlers Union; and, Special Agents Mutual Benefit Association.

We did not issue any 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.

Members of experience-rated plans have the option of using a designated network of providers or using out-of-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 an out-of-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued two experience-rated comprehensive medical plan audit reports during this reporting period. Highlighted below is a summary of the notable findings from one of the two audit reports.

### **Triple-S Salud, Inc.**

SAN JUAN, PUERTO RICO

Report No. 1D-89-00-12-036

MARCH 18, 2013

Triple-S Salud, Inc. (Plan) is a wholly-owned subsidiary of the Triple-S Management Corporation. The Plan is an experience-rated health maintenance organization plan offering comprehensive medical benefits to Federal enrollees and their families. Enrollment is open to all Federal employees and annuitants who live or work in the Plan's service area, which includes Puerto Rico and the U.S. Virgin Islands.

Our audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, such as refunds and pharmacy drug rebates; and administrative expenses from 2007 through 2011; as well as the Plan's cash management activities and practices related to FEHBP funds for those contract years.

During this period, the Plan processed approximately \$596 million in FEHBP health benefit payments and charged the FEHBP \$38 million in administrative expenses, other expenses, and retentions.

**Triple-S  
Salud, Inc. Returns  
\$2.4 Million for  
Miscellaneous Health Benefit  
Credits, Administrative  
Expenses, and Lost  
Investment Income**

Our auditors questioned \$2,394,593 in miscellaneous health benefit credits, administrative expenses and lost investment income, as follows:

- \$2,004,583 for unreturned pharmacy drug rebates, and \$320,613 for lost investment income on rebates that were either not returned to the FEHBP or not returned in a timely manner;



## AUDIT ACTIVITIES

- \$30,183 for unreturned health benefit refunds and recoveries, and \$4,203 for lost investment income on refunds and recoveries that were either not returned to the FEHBP or not returned in a timely manner;
- \$20,270 for a duplicate charge of system access fees, and \$2,825 for lost investment income on these funds; and,
- \$11,916 for unallowable administrative expenses charged to the FEHBP.

The Plan agreed with all of these questioned amounts. As a result of our findings, the Plan immediately returned \$2,394,593 to the FEHBP.



## 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 as well as provide Government-wide recruiting tools for Federal agencies and individuals seeking Federal jobs. 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.*

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 also responsible for performing an independent oversight of OPM's internal information technology and security program.

We perform an annual independent audit of OPM's information technology (IT) security environment, as required by the Federal Information Security Management Act of 2002 (FISMA). We also complete routine audits of OPM's major IT systems to ensure management has implemented appropriate security controls. When necessary, our auditors review system development projects to ensure adherence to best practices and disciplined system development lifecycle processes. During this reporting period we issued four final audit reports. Summaries of these audits are provided below.

### Information Systems General and Application Controls at Hawaii Medical Service Association

HONOLULU, HAWAII

Report No. 1D-97-00-12-012

OCTOBER 17, 2012

We conducted an audit of the claims processing applications used to adjudicate FEHBP claims for the Hawaii Medical Service Association (HMSA), as well as the various processes and IT systems used to support these applications. HMSA has two separate plans that service Federal employees: an experience-rated HMO plan referred to as FED87, and a nationwide fee-for-service plan sponsored by the BlueCross and BlueShield FEP.

HMSA has adequate IT security policies and procedures, and has implemented proper controls to secure its physical infrastructure and access to its IT systems. HMSA also has policies and procedures to ensure that changes to its system software are properly controlled. The most significant issues identified during this audit were related to business continuity and controls over its claims processing system.

**Strengthen  
Business Continuity  
Requirements and  
Controls Over HMSA's  
Claims Processing  
System**



We found that HMSA did not have a backup generator capable of handling the load of its primary facility and its data center in the event of a disruption to its main power supply. HMSA has since upgraded the generator and expects to have it online by June 2013.

In addition, we tested HMSA's claims processing system and found that certain controls that could identify and prevent fraudulent or abusive billing were missing. HMSA is still in the process of evaluating our recommendations for improvement, but has already added some system enhancements. We will continue to monitor HMSA's progress in this area.

**Federal Information Security Management Act FY 2012**

WASHINGTON, D.C.

Report No. 4A-CI-00-12-016

NOVEMBER 5, 2012

The Federal Information Security Management Act of 2002 (FISMA) is designed to ensure that the information systems and data supporting Federal operations are adequately protected. FISMA emphasizes that agencies 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 monitored 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) 2012 Reporting Instructions for FISMA and Agency Privacy Management. Our audit showed that while some progress has been made, the agency has not been able to implement the changes in its information security management structure to the degree that we consider necessary to improve the quality of its information security program.

Since FY 2007, we have reported a material weakness in the agency's information security program. The major problems reported were outdated and incomplete policies and procedures, and inadequate resources to manage an effective security program. While the agency has made recent progress in updating

its IT security and privacy policies, significant problems remain. In our opinion, the fundamental design of the program is flawed.

OPM chose to implement a decentralized model in which designated security officers (DSO) of major systems are appointed by and report to the program offices that own the systems. Very few of the DSOs have any background in information security. In addition, most DSOs do not have the skills necessary to effectively manage system security and are only managing their security responsibilities as a collateral duty. Although the Office of the Chief Information Officer (OCIO) provides guidance and training to the DSO community, the office lacks control over the DSOs enforcement of security requirements.

Given this environment, it is no surprise that our audit revealed multiple instances of non-compliance with FISMA requirements, particularly with respect to annual system controls and contingency plan testing that DSOs are required to perform. While updated policies and procedures are positive, they must be fully adopted by the target audience, in this case the DSO community. It is also questionable whether the DSOs have the resources necessary to implement the new policies and procedures.

In FY 2012, OPM took significant action to centralize its IT security function. OPM's Director issued a memorandum that transfers the DSO security responsibility to the newly created Information System Security Officer (ISSO) role, effective October 2012. By the end of FY 2012, the OCIO had filled three ISSO positions and assigned security responsibility for 17 of the agency's 47 information systems to these individuals.

While these actions are clearly positive steps that OPM has taken to centralize its IT security structure, the effort is not yet complete. The ISSOs have not performed any tangible security work for the systems they manage, and there are still many OPM systems

**Material Weaknesses Exist in OPM's Information Technology Control Structure**





that have not been assigned to an ISSO. As of March 2013, no additional positions have been filled and the decentralized DSO structure remains mostly intact. We have been told that funding problems have prevented further centralized restructuring and that OPM's OCIO is developing a new staffing proposal. Therefore, we continue to assess these issues to be a material weakness in OPM's information technology internal control structure.

## Information Systems General and Application Controls at EmblemHealth

NEW YORK, NEW YORK

Report No. 1D-80-00-12-045

DECEMBER 10, 2012

EmblemHealth has separate plans that service Federal employees: GHI Health Plan, GHI HMO Select Plans, and HIP Health of Greater New York. Our audit focused on the claims processing applications used to adjudicate FEHBP claims, and the various IT processes and systems used to support these applications.

We found that EmblemHealth has adequate controls in place in each of the control categories that we audited. However, we identified opportunities for improvement related to EmblemHealth's authentication controls over physical access to its data centers; its method for encrypting emails containing personally identifiable information; and in its configuration management program. The company has since remediated most of these weaknesses and is working to implement the necessary improvements for the remaining vulnerabilities.

**Opportunities  
for Improvement  
Recommended to Fortify  
Authentication Controls  
over Physical  
Access**

## Information System General and Application Controls at Aetna, Inc.

HARTFORD, CONNECTICUT

Report No. 1C-22-00-12-065

MARCH 18, 2013

Aetna (Plan) has two separate plans that service Federal employees: an HMO plan, referred to as Open Access; and a consumer driven, individual practice, high deductible health plan known as the "HealthFund." Our audit focused on the claims processing applications used to adjudicate FEHBP claims for both plans. We documented the controls in place and opportunities for improvement in each of the areas below.

### *Security Management*

Aetna has established a series of IT policies and procedures to create an awareness of IT security at the Plan. We also verified that Aetna has adequate human resources policies related to the security aspects of hiring, training, transferring, and terminating employees.

### *Access Controls*

Aetna has implemented numerous controls to grant and remove physical access to its data center, as well as logical controls to protect sensitive information. We also noted various controls over physical access to the data centers, as well as the method for encrypting emails containing sensitive information.

### *Network Security*

Aetna has developed thorough network security policies and procedures around its entire operating environment. We also noted numerous hardening controls around the internal network and that Aetna conducts routine configuration reviews. Aetna's incident response policies and procedures are comprehensive and utilize software packages for security event correlation in response to intrusion detection.



*Configuration Management*

Aetna has developed formal policies and procedures to ensure that system software is appropriately configured, updated, and configuration changes are controlled. However, we noted several weaknesses in Aetna’s configuration management program related to system configuration auditing and vulnerability scanning methodology. Aetna is working to implement the necessary changes for these vulnerabilities.

**Claims Application Control Weaknesses Cited**

*Contingency Planning*

We reviewed Aetna’s business continuity plans and concluded that they contained the key elements suggested by relevant guidance and publications.

We also determined that these documents are reviewed and updated on a periodic basis.

*Claims Adjudication*

Aetna has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we noted several weaknesses in Aetna’s claims application controls that could leave the system vulnerable to fraud or abuse.

*Health Insurance Portability and Accountability Act (HIPAA)*

Nothing came to our attention that caused us to believe that Aetna 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.*

During this reporting period we issued three final internal audit reports, which are summarized below.

#### **OPM's Fiscal Year 2012 Consolidated Financial Statements Audits**

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with Government Auditing Standards (GAS) issued by the Comptroller General of the United States. OPM contracted with the independent certified public accounting firm KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2012, and for the fiscal year (FY) then ended. The contract requires that the audit be performed in accordance with generally accepted Government auditing standards (GAGAS) and OMB Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

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

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

- Opinions on the consolidated financial statements and the individual statements for the three benefit programs;
- An internal controls report; and,
- A compliance report highlighting specific 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 in compliance with GAGAS and other authoritative references.

Specifically, we were involved in the planning, performance, and reporting phases of the audit; participating 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, 2012 and 2011. The contract requires that the audit be done in accordance with GAGAS and the OMB Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended. The U.S. Department of the Treasury and the Government Accountability Office review the closing package in preparing and auditing the *Financial Report of the United States Government*.



## OPM's FY 2012 Consolidated Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-12-039

NOVEMBER 7, 2012

KPMG audited OPM's balance sheets as of September 30, 2012 and 2011 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the Retirement, Health Benefits and Life Insurance programs (Programs), as of September 30, 2012 and 2011 and the Programs' related individual financial statements. 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 (CSRS)
- Federal Employees Retirement System (FERS)
- Federal Employees Health Benefits Program (FEHBP)
- Federal Employees' Life Insurance Program (LP)

KPMG reported that OPM's consolidated financial statements and the Programs' individual financial statements, as of and for the years ended September 30, 2012 and 2011, 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 two significant deficiencies in internal controls that remain unresolved from prior years. The areas identified by KPMG are:

• **Information Systems Control Environment (OPM and the Programs)**

In FY 2011, a material weakness was reported related to OPM's internal control environment due to the persistence of a number of long standing significant deficiencies in OPM's information security control environment. These significant deficiencies included: the lack of effective security program governance; deficiencies in certification and accreditation packages; and inaccurate Plans of Action and Milestones (POA&Ms). During FY 2012, OPM management demonstrated progress in addressing these long standing issues by reviewing and updating the Certification and Accreditation package for the Benefits Financial Management System and continuing to improve security program guidance. In addition, in August 2012, the Director of OPM directed the OPM Chief Information Officer (CIO) to establish a centralized system of Information System Security Officers (ISSOs) to manage information security across OPM's program offices. Nevertheless, significant deficiencies still remain in OPM's ability to identify, document, implement, and monitor information system controls.

**Internal Control Deficiencies Remain in Financial Reporting**

• **Controls over Financial Management and Reporting Processes of OPM Operational Activities and Related Data**

Certain deficiencies in the design and operation of controls over the financial management and reporting processes of OPM's operational activities continue to exist.

**Table 1** includes the significant deficiencies identified by KPMG during its audit of the financial statements for FY 2012 and 2011, respectively. OPM agreed with the findings and recommendations reported by KPMG.



**Table 1: Internal Control Weaknesses**

<b>Title of Findings From FY 2012 Report</b>	<b>Program/Fund</b>	<b>FY 2012</b>	<b>FY 2011</b>
Information Systems Control Environment	All	Significant Deficiency	Material Weakness
Controls over Financial Management and Reporting Processes of OPM Operational Activities and Related Data	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*, issued by the Comptroller General of the United States, and OMB Bulletin No. 07-04, *Audit Requirements for Federal Financial Statements*, as amended.

The objectives of KPMG’s audits of the special-purpose financial statements did not include expressing an opinion on internal controls or compliance with laws and regulations, and KPMG, accordingly, did not express such opinions. KPMG reported that OPM’s special-purpose financial statements are presented fairly, in all material respects.

**FY 2012  
Closing Package  
Statements Receive  
a Clean Opinion**

**OPM’s FY 2012 Special-Purpose  
Financial Statements**

WASHINGTON, D.C.

**Report No. 4A-CF-00-12-040**

NOVEMBER 15, 2012

The special-purpose financial statements, also referred to as closing package financial statements, are 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, statements of net cost, statements of changes in net position, and accompanying financial report notes, reported as of September 30, 2012 and 2011;
- The Additional Note No. 31 (discloses other data necessary to make the Special-Purpose Financial Statements more informative); and,
- The Trading Partner balance sheets, statements of net cost, and statements of changes in net position (showing the funds due between OPM and other agencies) as of September 30, 2012.

KPMG did not identify any material weaknesses or significant deficiencies involving internal controls over the financial process for the special-purpose financial statements. In addition, KPMG disclosed no instances of noncompliance or other matters that are required to be reported.

**OPM’s Fiscal Year 2012  
Improper Payments Reporting**

WASHINGTON, D.C.

**Report No. 4A-CF-00-13-016**

MARCH 11, 2013

We conducted a performance audit of OPM’s Fiscal Year 2012 Improper Payments Reporting for compliance with the Improper Payments Elimination and Recovery Act of 2010 (IPERA). This was our second audit of OPM’s compliance with IPERA. This audit was conducted pursuant to IPERA guidance issued by the Office of Management and Budget (OMB) requiring agency Inspectors General to review their agency’s improper payments reporting in the Agency Financial Report (AFR) for compliance with





IPERA. The criteria for compliance with IPERA are the following:

- Publish an AFR for the most recent fiscal year and post the report and any accompanying materials required by OMB on the agency's website;
- Conduct program specific risk assessments of all programs and activities to identify those that are susceptible to significant improper payments;
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment in the AFR;
- Publish programmatic corrective action plans in the AFR;
- Publish and meet annual reduction targets for each program assessed to be at risk for improper payments;
- Report a gross improper payment rate of less than ten percent for each program or activity for which an improper payment estimate was obtained and published in the AFR; and,

- Report information on its efforts to recapture improper payments.

The objective of our audit was to determine if OPM's improper payments reporting in the AFR was in compliance with IPERA requirements. We determined that OPM is in compliance with IPERA reporting requirements; however, the agency can improve the discussion of its efforts to recapture its improper payments by including an in-depth description of all of the methods used to recapture overpayments. OPM concurs with the finding and recommendation and has indicated it will complete corrective actions by November 2013.

We also reviewed OPM's progress in addressing the findings and recommendations from our previous audit. The recommendations from our previous audit have been satisfactorily resolved, except for the development of documented internal controls over the reporting of improper payments.

**OPM is in  
Compliance with  
IPERA Reporting  
Requirements**



## Special Audits

*In addition to health and life 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 designations of contributing employees.*

**D**uring this reporting period we issued two special audit final reports, which are summarized below.

### **Federal Flexible Spending Account Program's Operations as Administered by OPM**

WASHINGTON, D.C.

Report No. 4A-RI-00-12-024

FEBRUARY 6, 2013

The Federal Flexible Spending Account Program (Program) was established at the direction of the President, in October of 2000. It was implemented by OPM as a Health Insurance Premium Conversion Plan under 5 Code of Federal Regulations Part 550. This Program is available to active Federal employees who participate in the FEHBP. OPM has the overall responsibility for oversight of the Program. Its oversight responsibilities are funded by budgeted appropriations and are not paid by Federal employees through payroll deductions. OPM's responsibilities include, but are not limited to, the following:

- To maintain and update the FSAFEDS program website;

- To annually review and set the program's Risk Reserve fee;
- To perform annual reconciliations of the Risk Reserve account;
- To act as a liaison between Federal agencies and the Program's contractor;
- To facilitate the promotion of the FSAFEDS Program in the Federal Government; and,
- To respond in a timely manner to a contractor's request for information and assistance.

During this reporting period, we issued a report on the Program's operations for the years 2006 through 2009. Specifically, the audit covered OPM's administrative responsibilities related to program operations, cash management, and fraud and abuse policies and procedures.

The audit identified one procedural finding and made recommendations for three areas of improvement. Specifically, we found that:

**Program  
Held \$37 Million  
in Excess of its  
Target Reserve  
Balance**



- OPM could not provide documentation to support its annual reviews of the Risk Reserve surcharge (Risk Reserve fee) as required by the Contract. Consequently, our review of this account as of the end of contract year 2011 showed that the total of the reserves was \$37 million in excess of the target balance;
- OPM had no policies and procedures in place for maintaining and reconciling the Risk Reserve account, and for reviewing the Risk Reserve fee;
- OPM charged expenses in excess of its budget to administer the Program and erroneously charged FSAFEDS salary-related expenses to its Trust Fund account, of which FSAFEDS is not a part. By charging FSAFEDS expenses to the improper account, it places other activities at risk of being under-funded. Additionally, labor codes for FSAFEDS are improperly linked to the Trust Fund, also placing the Trust Fund at risk for the charging of unallowable expenses against it; and,
- OPM did not formally resolve open items from a review of FSAFEDS that was issued in November 2007 by OPM’s Center for Internal Control and Risk Management. Had all of these recommendations been formally resolved and corrective actions properly implemented, audit issues identified in our report may have been reduced or eliminated.

All issues identified in this audit have been resolved by OPM’s Audit Resolution Group.

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## **Mail Handlers Benefit Plan’s Pharmacy Operations as Administered by CaremarkPCS Health**

NORTHBROOK, ILLINOIS  
Report No. 1B-45-00-12-017  
DECEMBER 13, 2012

The Mail Handlers Benefit Plan (Plan) began participating in the FEHBP in 1963 under Contract

CS 1146 between OPM and the National Postal Mail Handlers Union. The Plan is an experience-rated fee-for-service plan underwritten by First Health Life & Health Insurance Company and Cambridge Life Insurance Company (Coventry Health Care, Inc.).

PBMs are primarily responsible for processing and paying prescription drug claims, which typically include both retail and mail order drug benefits. The PBM is used by the Plan to develop, allocate, and control costs related to the pharmacy claims program. The Plan’s pharmacy operations and responsibilities under Contract CS 1146 are carried out by the PBM (CaremarkPCS Health), which is located in Northbrook, Illinois, and is a subsidiary of the CVS Caremark Corporation.

The audit covered pharmacy claims and the Plan’s adherence to its contractual requirements for contract years 2009 and 2010. Pharmacy claim payments for both years totaled \$792,077,332.

The audit identified one procedural finding related to the Plan’s fraud and abuse program. Specifically:

- The Plan’s 2009 annual fraud and abuse report, which was submitted to OPM in March 2010, was missing a costs and benefits analysis of the Plan’s fraud and abuse program; and,
- The Plan’s 2009 annual fraud and abuse report did not address the number of cases referred to the agency and the OIG.

The Plan submitted its 2009 annual fraud and abuse report without several critical elements required by OPM, therefore the effectiveness of the Plan’s fraud and abuse program could not be assessed.

This procedural issue has since been resolved by OPM’s Audit Resolution Group.



## COMBINED FEDERAL CAMPAIGN

*Our office audits the Combined Federal Campaign (CFC), the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM 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.

While CFC audits do not identify savings to the Government, because the funds involved are charitable donations made by Federal employees, the audits identify inappropriate expenses charged by the campaign administrators, recommend redistributing monies to the appropriate charities, and recommend program improvements to promote campaign efficiency and effectiveness. Additionally, our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's Office of the Combined Federal Campaign (OCFC) works with the campaign administrators 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 Director of OPM to conduct the CFC in a particular community. It organizes the local CFC; determines the eligibility of local charities; selects and supervises the activities of the Principal Combined Fund Organization (PCFO); encourages Federal agencies to appoint employees to act as Loaned

Executives who work directly on the local campaign; ensures that Federal employees are not coerced to participate in the local campaign; 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. The primary goal of the PCFO is to administer an effective and efficient campaign in a fair and even-handed manner aimed at collecting the greatest amount of charitable contributions possible. Its responsibilities include collecting and distributing CFC funds, training volunteers, maintaining a detailed accounting of CFC administrative expenses incurred during the campaign, preparing pledge forms and charity lists, and submitting to and cooperating fully with audits of its operations. The PCFO is reimbursed for its administrative expenses from CFC funds.

- **Federations**

A federation is a group of 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.

**Recommended  
Mergers of Two  
Campaigns Due to  
Non-Compliance  
with Program  
Regulations**



During this reporting period we issued three audit reports of local CFCs, which are summarized below.

Due to the numerous audit findings and the nature of the identified issues in two of the three audits, we recommended that the Delaware CFC and the Sun Country CFC be merged with other geographically adjacent campaigns, and be administered and conducted by new PCFOs and LFCCs that were more equipped to handle the responsibilities of the CFC.

Of continued concern to the OIG is the consistent identification of similar issues from audit to audit. The causes for these issues are, more often than not, attributed to one of the following program concerns:

- The PCFO was either not aware of, did not understand its responsibilities as defined in the regulations and CFC memoranda, or simply did not follow said regulations and memoranda;
- The LFCC was either not aware of or did not understand its responsibilities as defined in the regulations;
- The LFCC is inactive and does not perform the needed oversight of the PCFO; and,
- The IPAs hired to perform the agreed-upon procedures audit, which is paid for out of campaign funds, do not understand the requirements of the audit, which results in findings not being identified and communicated to the PCFOs and LFCCs.

### 2009 and 2010 Overseas Combined Federal Campaigns

ALEXANDRIA, VIRGINIA

Report No. 3A-CF-00-12-046

MARCH 18, 2012

The third CFC audit performed during this reporting period was an audit of the Overseas CFC, the second largest campaign in the CFC. This audit covered campaign years 2009 through 2010 and identified the following issues:

- **Agreed-Upon Procedures Not in Compliance with the Audit Guide**  
The Independent Public Accountant utilized by the PCFO and LFCC to complete the Agreed-Upon Procedures for the 2009 campaign did not perform

its review in accordance with the requirements of the Audit Guide.

- **Campaign Expenses**  
The PCFO charged the 2010 campaign \$16,301 in expenses that were either unallowable or attributable to another campaign. Additionally, we identified \$10,000 related to software licensing fees that could have been put to better use.
- **Interest Expense Allocation**  
The PCFO allocated interest expenses improperly among multiple campaigns.
- **Banking and Credit Card Fees**  
The PCFO did not adhere to its responsibility to conduct a campaign aimed at maximizing the charitable contributions donated by both Federal employees and members of the United States Military serving overseas.
- **Pledge Form Errors Identified**  
Our pledge form review identified 12 pledge forms with a combined total of 17 errors.
- **Donor Names Incorrectly Released**  
The PCFO incorrectly released donor names to charities when no release of information was authorized by the donor.
- **CFC Funds Not Maintained in Interest-Bearing Accounts**  
Not all CFC bank accounts utilized by the PCFO maintained CFC funds in interest-bearing accounts as required by the regulations.
- **Un-Cashed Check Procedures**  
The PCFO's policies and procedures related to un-cashed checks did not include at least three documented follow-up attempts to reach each payee.
- **One-Time Disbursement Percentage Calculation**  
The PCFO did not properly calculate the pledge loss percentage that was applied to agencies receiving one-time disbursements.

We provided audit findings and recommendations for corrective action to OPM's management. OPM notified the Overseas PCFO of our recommendations and is monitoring any corrective actions. If the Overseas PCFO does not comply with the recommendations, the Director of OPM 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 \$920 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 30 criminal investigations and closed 47, with 97 still in progress. Our criminal investigations led to 20 arrests, 21 indictments and informations, 15 convictions and \$15,343,149 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 \$871,006,675 in criminal fines and penalties which are 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. Of particular concern are the growth of medical identity theft and organized crime in health care fraud, which has affected the FEHBP.

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. 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 debaring 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

#### **Amgen Agrees to Pay \$762 Million Settlement for Introducing Misbranded Drug, Aranesp Into Interstate Commerce**

In December 2012, Amgen pled guilty to illegally introducing a misbranded drug into interstate commerce. The plea was part of a global settlement with the United States in which Amgen agreed to pay \$762 million to resolve criminal and civil liability arising from its sale and promotion of certain drugs. This represents the single largest criminal and civil False Claims Act settlement involving a biotechnology company in U.S. history.

Under the Food, Drug and Cosmetic Act, it is illegal for drug companies to introduce into the marketplace drugs that the company intends to promote "off-label," i.e., for uses or at doses not approved by the Food and Drug Administration (FDA). Aranesp, an erythropoiesis-stimulating agent (ESA), was approved at calibrated doses for particular patient populations suffering from anemia. Amgen promoted Aranesp to be used at off-label doses that the FDA had specifically considered and rejected, and for an off-label treatment that the FDA had never approved. Under the terms of the criminal plea agreement, Amgen will pay a criminal fine of \$136 million and criminal forfeiture in the amount of \$14 million.

The civil settlement resolves allegations that Amgen caused false claims to be submitted to Medicare,

Medicaid and other Government insurance programs. The civil settlement also included that Amgen:

- Promoted for off-label uses and doses two other drugs that it manufactured, Enbrel and Neulasta;
- Offered illegal kickbacks to a wide range of entities in an effort to influence health care providers to select its products for use, regardless of whether they were reimbursable by Federal health care programs or were medically necessary; and,
- Engaged in false price reporting practices involving several of its drugs.

As a result of the settlement, the FEHBP received \$5,504,931. This case was jointly investigated by the Defense Criminal Investigative Service (DCIS); Federal Bureau of Investigation (FBI); the FDA; and the OIGs of the Department of Health and Human Services (HHS); Railroad Retirement Board (RRB); Department of Veterans Affairs (VA); and our office.

#### **FEHBP Receives Over \$4.6 Million from Boehringer Ingelheim Pharmaceuticals, Inc.**

Boehringer Ingelheim Pharmaceuticals, Inc. (BIPI), a pharmaceutical manufacturer, entered into a settlement agreement with the Government, agreeing to pay \$95 million to resolve False Claims Act allegations in connection with the marketing of some of its most popular drugs. The investigation developed as a result of a qui tam filed against BIPI. The lawsuit alleged that BIPI unlawfully marketed its drugs Aggrenox, Combivent, and Micardis, and caused false claims to be submitted to state and Federal health care programs. The FDA has approved Aggrenox to prevent secondary strokes; Combivent to treat continued symptoms of a bronchospasm in patients with Chronic Obstructive Pulmonary Disease (COPD) who already are on a bronchodilator; and, Micardis to treat hypertension.

The suit alleged that BIPI unlawfully marketed several drugs for uses not approved by the FDA and therefore not covered by the Federal health care programs, specifically:

- Aggrenox for a variety of uses, including for certain cardiovascular events such as myocardial infarction and peripheral vascular disease;



- Combivent for use prior to another bronchodilator in treating COPD; and,
- Micardis for the treatment of early diabetic kidney disease.

In addition, it was alleged that BIPI knowingly:

- Promoted the sale and use of Combivent and Atrovent at doses that exceeded those covered by Federal health care programs;
- Made unsubstantiated claims about the efficacy of Aggrenox; and,
- Paid kickbacks to health care professionals to induce them to prescribe Aggrenox, Atrovent, Combivent, and Micardis.

As a result of the settlement, the FEHBP received \$4,621,374. This was a joint investigation conducted by DCIS, FDA, and the OIGs of the VA, HHS, and our office.

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### **International Drug Manufacturer Sanofi Violates the False Claims Act, Agrees to Pay \$109 Million Settlement**

In December 2012, Sanofi-Aventis U.S. Inc. and Sanofi-Aventis U.S. LLC, subsidiaries of international drug manufacturer Sanofi (collectively, Sanofi U.S.), agreed to pay \$109 million to resolve allegations that Sanofi U.S. violated the False Claims Act and the Anti-Kickback Statute by giving physicians free units of Hyalgan, a knee injection, to induce them to purchase and prescribe the product.

The settlement also resolved allegations that Sanofi U.S.:

- Submitted false average sales price (ASP) reports for Hyalgan that failed to account for the free units distributed contingent on Hyalgan purchases. These false ASP reports were used to set reimbursement rates, which caused Government programs to pay inflated amounts for Hyalgan and a competing product.
- Provided its sales representatives with thousands of free “sample” Hyalgan units and trained its sales

representatives to market the “value add” of these units to physicians. Sanofi U.S. sales representatives often entered into illegal sampling arrangements with physicians, using the free units as kickbacks and promising to negotiate a lower effective price.

- Surreptitiously lowered the effective price of Hyalgan by promising free units to doctors who agreed to purchase the product.

As a result, Medicare and other Federal health care programs paid millions of dollars in kickback-tainted claims for Hyalgan. Although the Anti-Kickback Statute does not apply to the FEHBP, the FEHBP was able to recover funds in this case due to the violations of the False Claims Act. Our office has recommended a legislative change to include the FEHBP in the Anti-Kickback Statute in order to better protect the FEHBP and its beneficiaries from similar frauds.

As result of the settlement, the FEHBP received \$2,468,484. The case was jointly investigated by the FBI, and the OIGs of HHS, the U. S. Postal Service (USPS), and our office.

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### **FEHBP Receives Settlement from Blackstone Medical Inc., an Orthofix Subsidiary**

In October 2012, Orthofix International NV agreed to pay the United States \$30 million to settle allegations that an Orthofix subsidiary, Blackstone Medical Inc., paid illegal kickbacks to physicians in order to induce use of the company’s products during spinal surgeries.

The kickbacks provided by Blackstone took many forms, including fictitious “consulting” agreements, stock options, gifts, travel, unrestricted grants, and entertainment. These payments and benefits resulted in the submission of false claims for payment to Government health care programs and violated the Federal False Claims Act. The conduct in question is alleged to have taken place between October 2000 and September 2007, a period which spans both Blackstone’s existence as an independent company, and its acquisition as an Orthofix subsidiary in 2006.

As a result of the settlement, the FEHBP received \$826,960. This case was jointly investigated by the FBI, DCIS, and the OIG of HHS, and our office.





### **U.S. Navy Doctor Falsifies FEHBP Prescriptions for Self**

In November 2011, a FEHBP subscriber reported that she discovered discrepancies while reviewing her prescription history. The prescription history reflected that the individual had received prescriptions from a physician, an active duty U.S. Navy doctor, for which her insurance company was billed. However, she did not receive those medications nor did she use the pharmacy where the prescriptions were filled.

The investigation revealed that from about January through November 2011, the physician called in falsified prescriptions using FEHBP members' identities to obtain controlled substances for his own use. These fraudulent prescriptions led to the submission of false claims to the FEHBP.

The physician pled guilty to obtaining controlled substances by fraud and aggravated identity theft. He was sentenced to 24 months and one day of imprisonment and 12 months of supervised release. In addition, he was ordered to pay restitution in the amount of \$2,799, of which \$1,623 will be returned to the FEHBP. The physician was also required to participate in a substance abuse program.

This was a joint investigation with the Naval Criminal Investigative Service (NCIS), the FBI, and our office.

### **FEHBP Recovers \$438,701 from Sheridan Healthcare**

In December 2012, a physician management practice, Sheridan Healthcare Inc. (Sheridan), entered into a settlement agreement with the Government agreeing to resolve False Claims Act allegations. The allegations stemmed from the medical unbundling of labor and delivery charges for newborn hearing screenings outside of the global hospital charges, commonly referred to as Diagnosis-Related-Group (DRG) charges or negotiated hospital per diem rates. Sheridan incorrectly billed for newborn hearing screenings by billing for them separately. This activity caused Sheridan to be compensated from Government sponsored programs for more than they would have received.

As a result of the settlement, the FEHBP received \$438,701. This case was identified through the

proactive efforts of a working group comprised of personnel from our office and the FEHBP Carrier Special Investigations Units. It was jointly investigated by the FBI, the DCIS, and our investigators.

### **St. Joseph's Medical Center Voluntarily Discloses Overpayment of \$4.9 Million**

St. Joseph's Medical Center, located in Towson, Maryland, voluntarily disclosed an overpayment for services rendered from October 2007 through October 2009 in October 2012. An independent audit, initiated by St. Joseph's Medical Center (Center), disclosed that the Center received overpayments for medically unnecessary hospital short-stay admissions (admissions of two days or less) from multiple Government agencies. St. Joseph's Medical Center voluntarily disclosed this information to Federal authorities.

In February 2013, the U.S. Department of Justice, on behalf of the U.S. Department of Health and Human Services (DHHS), TRICARE Management Activity, OPM, and the State of Maryland, negotiated a Settlement Agreement with St. Joseph's Medical Center in the amount of \$4,900,704.

The FEHBP received \$107,710 as a result of the settlement.

## **RETIREMENT FRAUD**

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). The most common type of retirement fraud involves the intentional receipt and use of Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS) annuity benefit payments by an unentitled recipient.

However, retirement fraud can also include incidents of elder abuse. For example, the District Attorney's Office in Philadelphia is creating a multi-agency Elder Justice Task Force, in response to a referral from our office. Participating agencies include the Philadelphia District Attorney's Office, Social Security OIG, DHHS OIG, the U.S. Attorney's Office, and our office. The OIG investigation which inspired this new Task Force involved the caregiver of a Federal annuitant, who was designated as the annuitant's representative payee. After the annuitant was admitted



to a nursing home, the caregiver kept the annuitant's monthly retirement payments for personal use, instead of using the money to pay for the annuitant's care. The caregiver was arrested in February 2013, and the results of her prosecution will be reported in a future Semi-Annual Report.

Our Office of Investigations uses a variety of approaches to identify potential retirement fraud cases for investigation. We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. 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 coordinate 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.

The OIG also works proactively to identify retirement fraud. For example, in the fall of 2012, the OIG initiated a data-matching project to try to identify deceased annuitants still receiving monthly retirement or survivor annuity payments from OPM. From the annuity rolls, the OIG identified annuitants over age 92 enrolled in a BlueCross BlueShield plan. Then, the OIG conducted a data-match between the annuity roll snapshot and the FEHBP Claims Data Warehouse, in order to identify annuitants who have not filed any insurance claims with BCBS in the last two years. The OIG attempted to make contact with this annuitant population and is in the process of verifying the vital status of those whom the OIG was unable to reach. The OIG has notified the Retirement Inspection Branch of those annuitants whose vital status is in question, so that the Retirement Inspection Branch may take action to suspend payment, as appropriate. The results of this proactive project will be reported in a future Semiannual Report to Congress.

The following retirement investigations represent some of our activities during the reporting period.

## RETIREMENT FRAUD CASES

### **Granddaughter Conceals Death, Collects Stolen Annuity Payments**

We initiated this investigation in May 2007, after receiving allegations from the VA OIG that a deceased survivor annuitant's granddaughter fraudulently

obtained retirement payments from OPM. At the time of the referral, the VA OIG was also investigating the granddaughter for illegally cashing her grandmother's VA benefits checks.

Our office contacted the financial institution where the annuity payments were deposited for the deceased survivor annuitant. It was determined that the annuity payments were sent via electronic funds transfer and deposited into a bank account in the name of the survivor annuitant's granddaughter.

Our investigation revealed that the survivor annuitant died in April 1986 and OPM was never notified of her death. For 21 years, the granddaughter collected her grandmother's Federal veterans and survivor annuity benefits, and deposited the checks into her own personal account, receiving \$161,757 in fraudulent benefits from OPM.

The granddaughter was indicted and subsequently arrested in April 2012 and pled guilty to theft of public money, wire fraud, and social security fraud in July 2012. In October 2012, the granddaughter was sentenced to 33 months in prison, followed by three years of supervised release. Additionally, the granddaughter was ordered to pay restitution in the amount of \$161,757 to OPM.

This was a joint investigation by the OIGs for the SSA, VA, Housing and Urban Development (HUD), and our office.

### **Former Nursing Home Employee Steals Deceased Annuitant's Benefit Checks**

This case was discovered through OPM's Retirement Services' "1099R Project," which involved undelivered 1099-R tax forms which were returned to OPM. As a result of our investigation, we determined that the annuitant died in April 2002 and OPM was never notified of his death.

*Form 1099-R is used to report the distribution of retirement benefits such as pensions, annuities or other retirement plans. Variations of Form 1099-R include: Form CSA 1099R, Form CSF 1099R, and Form RRB-1099R. Most public and private pension plans that are not part of the Civil Service system use the standard Form 1099-R.*





An IG subpoena of the bank records revealed that the annuity checks were deposited into a credit union account not associated with the annuitant from approximately June 2005 through June 2007. Also, an analysis of the U.S. Treasury checks indicated that several checks were endorsed by someone other than the annuitant.

In July 2010, the person whose name appeared on the back of the annuity checks was interviewed by OIG investigators. Our investigation disclosed that this individual was employed as a Social Services Assistant at the Rosewood Terrace Care and Rehabilitation Center where the annuitant resided. Prior to his death, the annuitant asked the Social Services Assistant to run errands for him, and gave her his automated teller machine (ATM) bank card and personal identification number (PIN) to pay for items purchased.

In 2002, the hospital where the annuitant passed away informed the assistant of his death. The assistant stated that she took possession of the annuitant's property from both the hospital and the nursing home, which included his wallet.

In August 2011, the assistant (defendant) was indicted for theft of Government funds and subsequently arrested. In May 2012, the defendant pled guilty and was sentenced in December 2012 to serve five months in prison to be followed by 36 months of supervised release.

The defendant was also ordered by the court to pay restitution in the amount of \$98,044 to OPM.

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### **Son Steals Deceased Mother's Annuity**

An OPM death match conducted with Social Security Administration in January 2007, revealed that the survivor annuitant died in November 1985. Since OPM was never notified of the death, annuity payments continued resulting in an overpayment of \$191,303.

In January 2010, we issued a subpoena for bank records associated with the account where the monthly Federal annuity benefits were paid electronically. The bank provided information that the account was jointly held by the annuitant and her son. As a result of our investigation, the son was indicted and arrested in October 2011 for theft of Government funds.

In September 2012, the defendant pled guilty and was sentenced in January 2013 to serve six months in prison, followed by six months of home detention with electronic monitoring, and 36 months of supervised release.

He was also ordered by the court to pay full restitution to OPM in the amount of \$191,303.

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## **SPECIAL INVESTIGATION CASES**

### **Charity Founder Steals from Charity**

The OIG received an allegation from the U.S. Postal Inspection Service regarding a charity participating in the Federal Government's CFC. It was alleged that the charity founder (the founder) engaged in a scheme to defraud the charity and its donors.

Our investigation revealed that the founder fabricated detailed accounts of having "rescued" lost or stolen Holocaust-era Torahs and other Jewish artifacts in order to solicit charitable contributions, some of which he diverted into his own personal bank accounts.

In August 2011, the founder was arrested and charged with mail and wire fraud. In February 2012, the founder pled guilty to defrauding the charity and its donors out of at least \$862,044.

In October 2012, the founder was sentenced to a term of imprisonment of 51 months, 100 hours of community service, 36 months of supervised release, and ordered to make restitution to the victims. As a result, the CFC received \$31,283 in restitution.

This case was worked jointly by the U.S. Postal Inspection Service, U.S. Immigration and Customs Enforcement, and our office.

## **REVOLVING FUND PROGRAM INVESTIGATIONS**

Our office investigates OPM employee misconduct and other wrongdoing, including allegations of fraud within OPM's revolving fund programs, such as the background investigations program and human resources products and services.



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 over 90 percent of all personnel background investigations for the Federal Government. With a staff of over 9,300 Federal and contract employees, FIS processed over 2.2 million background investigations in FY 2012. 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 criminal investigators include fabrications by OPM 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's Human Resources Solutions (HRS) provides other Federal agencies, on a reimbursable basis, with human resource products and services to help agencies develop leaders, attract and build a high quality workforce, and transform into high performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following FIS investigations represent some of our activities during the reporting period.

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### **Former OPM Background Investigator Sentenced for Falsifying Numerous Background Investigations**

In June 2011, the OIG received an allegation from the Integrity Assurance Group of FIS regarding misconduct and false statements made by an OPM background investigator.

Between August 2010 and June 2011, in more than three dozen background Reports of Investigations, the background investigator represented that she had interviewed a source or reviewed a record regarding the subject of the background investigation, when in fact, she had not conducted the interview or obtained the record. These reports were utilized and relied upon by Federal agencies to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator, costing \$109,000.

Our criminal investigators interviewed the background investigator in question, who admitted she randomly falsified reports, to include, various source contacts and personal testimony. She also admitted that she did not obtain or review documentary evidence, such as employment and medical record reports, to verify and corroborate information to support the background investigation.

In July 2012, an Information was filed by the U.S. Attorney's Office charging the background investigator with making false statements and she was subsequently arrested. In August 2012, the background investigator pled guilty in Federal court to making a false statement. In February 2013, she was sentenced to 180 days of home detention, 36 months of probation, 150 hours of community service, and ordered to pay full restitution of \$109,000 to OPM.

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### **Former OPM Background Investigator Sentenced for Falsifying Records**

In February 2012, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by a background investigator. The allegation further stated that a Senior Cadet at the U.S. Air Force Academy (USAFA) informed a FIS supervisor that they were interviewed by a background investigator regarding a fellow cadet's personal background investigation. However, the Senior Cadet was concerned because he was never interviewed for his own personal background investigation, which was conducted for a Top Secret clearance and admittance to the USAFA flight



program. A subsequent review revealed that the background investigator falsely reported that the Senior Cadet was interviewed.

In March 2012, the background investigator was interviewed by FIS investigators and admitted to falsifying the Senior Cadet's interview and further admitted to falsifying numerous interviews in background Reports of Investigation. The background investigator also admitted that he did not obtain or review documentary evidence to verify and corroborate information supporting his reports.

FIS conducted a full scope recovery effort reinvestigation of the background investigator's work, and confirmed that between June 2011 and March 2012, in more than a dozen background Reports of Investigation, the background investigator represented that he had interviewed a source or reviewed a record, when in fact, he had not. These reports were relied upon by Federal agencies requesting the background investigations to determine whether the subjects were suitable for positions having access to classified information, for positions impacting national security, or for receiving or retaining security clearances.

In August 2012, an Information was filed by the U.S. Attorney's Office charging the background investigator with making false statements and he was subsequently arrested. In November 2012, the background investigator pled guilty to making a false statement. In March 2013, he was sentenced to three months incarceration, 180 days of home detention, 12 months of supervised probation, required to participate in a mental health treatment program, and ordered to pay \$38,238, which represents full restitution to OPM for the cost to reinvestigate his work.

### OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number, email address, and mailing address is listed on our OIG Web site at [www.opm.gov/oig](http://www.opm.gov/oig), along with an online anonymous complaint form. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans. Those who report information to our Hotline

can do so openly, anonymously, and confidentially without fear of reprisal.

The information we receive on our OIG Hotline generally concerns customer service issues, 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.

We received 620 hotline inquiries during the reporting period, with 225 pertaining to health care and insurance issues, and 395 concerning retirement or special investigation. The table on page 29 reports the summary of hotline activities including telephone calls, emails, and letters.

### OIG and External Initiated Complaints

Based on our knowledge of OPM program vulnerabilities, information shared by OPM program offices and contractors, and our liaison with other law enforcement agencies, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we initiated 61 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 452 health care fraud preliminary inquiry complaints. These efforts may potentially evolve into formal investigations.

We believe that these OIG and external initiated complaints complement our hotline 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, 2012, we inadvertently over reported \$518,998 involving the settlement of one health care investigation. The over reporting occurred because the initial FEHBP allocation of the settlements provided by DOJ was overstated and was not readjusted by DOJ until after the prior Semiannual Report was issued.



## 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 32,257 active suspensions and debarments from the FEHBP.*

During the reporting period, our office issued 392 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 3,123 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.*

The following is a summary of one of our debarment actions.

### **Enrollee's Request to Continue to Receive Services From Debarred Provider is Denied**

In September 1996, we debarred a New York dentist from participating as a health care provider in the FEHBP based on his exclusion by HHS from participating in Medicare and Medicaid. In accordance with Federal law and regulations, our office must debar any health care provider who has been excluded by another Federal agency.

Debarred providers are not eligible to receive payment of FEHBP funds, thus if claims continue to be submitted, they may be considered as violations of the Federal false claims statutes. However, an exception is permitted if the enrollee can demonstrate either:

- A medical condition serious enough that interrupting care by the provider could have a negative impact on her health, or
- A lack of alternative medical services within her geographic area.



## ENFORCEMENT ACTIVITIES

In January 2013, a FEHBP health insurance plan (Plan) submitted a FEHBP enrollee request for an exception to our debarment of her dentist. The enrollee requested that she be allowed to continue receiving services from the debarred dental provider under her FEHBP health plan. The Plan recommended that the enrollee's request be denied because her justification did not address a medical necessity or lack geographical alternative to justify using Federal funds to pay the debarred dental

provider. Additionally, the Plan agreed to work with the enrollee to find alternative dental care within her geographical region.

Our debarring official concurred with the Plan's recommendation to deny the enrollee's requests and issued a denial letter to the enrollee, explaining that she did not demonstrate the existence of a qualifying medical condition or the lack of alternative medical services within her geographical area.





# STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

## Judicial Actions:

Arrests . . . . .	20
Indictments and Informations . . . . .	21
Convictions . . . . .	15

## Judicial Recoveries:

Restitutions and Settlements . . . . .	\$15,343,149
Fines, Penalties, Assessments, and Forfeitures . . . . .	\$871,006,675 <sup>1</sup>

## Retirement and Special Investigations Hotline and Preliminary Inquiry Activity:

### HOTLINE

Referred to:

OPM Program Offices . . . . .	165
Other Federal Agencies . . . . .	111
Informational Only . . . . .	110
Inquiries Initiated . . . . .	2
Retained for Further Inquiry . . . . .	7
Total Received: . . . . .	395

### PRELIMINARY INQUIRY COMPLAINTS

Total Received: . . . . .	61
Total Closed: . . . . .	60

(Continued on next page)

<sup>1</sup>This 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.



**Health Care Fraud Hotline and Preliminary Inquiry Complaint Activity:**

**HOTLINE**

Referred to:

OPM Program Offices . . . . .	77
FEHBP Insurance Carriers or Providers . . . . .	99
Other Federal Agencies . . . . .	16
Informational Only . . . . .	31
Inquiries Initiated . . . . .	0
Retained for Further Inquiry . . . . .	2
Total Received: . . . . .	225

**PRELIMINARY INQUIRY COMPLAINTS**

Total Received: . . . . .	452
Total Closed: . . . . .	375

**Hotline Contacts and Preliminary Inquiry Complaints:**

Total Hotline Contacts and Preliminary Inquiries Received: . . . . .	1,133
Total Hotline Contacts and Preliminary Inquiries Closed: . . . . .	1,046

**Administrative Sanctions Activity:**

Debarments and Suspensions Issued . . . . .	392
Health Care Provider Debarment and Suspension Inquiries . . . . .	3,123
Debarments and Suspensions in Effect at End of Reporting Period . . . . .	32,257

# APPENDICES

## APPENDIX I Final Reports Issued with Questioned Costs for Insurance Programs

OCTOBER 1, 2012 TO MARCH 31, 2013

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$ 585,590
B. Reports issued during the reporting period with findings	12	11,970,560
Subtotals (A+B)	13	12,556,150
C. Reports for which a management decision was made during the reporting period:	13	12,556,150
1. Disallowed costs	N/A	13,064,587
2. Costs not disallowed	N/A	(508,437) <sup>2</sup>
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

<sup>2</sup>Represents the net of allowed costs, which includes overpayments and underpayments, to insurance carriers.



## APPENDIX II – A

### Final Reports Issued with Recommendations for All Other Audit Entities

OCTOBER 1, 2012 TO MARCH 31, 2013

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	\$350,679
B. Reports issued during the reporting period with findings	2	31,472
Subtotals (A+B)	6	382,151
C. Reports for which a management decision was made during the reporting period:	2	314,203
1. Disallowed costs	N/A	314,203
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	67,948
E. Reports for which no management decision has been made within 6 months of issuance	2	36,476

## APPENDIX II – B

### Final Reports Issued with Recommendations for Better Use of Funds

OCTOBER 1, 2012 TO MARCH 31, 2013

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	10,000
Subtotals (A+B)	0	0
C. Reports for which a management decision was made during the reporting period:	0	0
D. Reports for which no management decision has been made by the end of the reporting period	1	10,000
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, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued	Questioned Costs
1A-10-41-12-019	BlueCross BlueShield of Florida in Jacksonville, Florida	October 17, 2012	\$ 448,133
1C-65-00-12-053	Kaiser Foundation Health Plan of Colorado in Aurora, Colorado	October 17, 2012	0
1C-57-00-12-051	Kaiser Foundation Health Plan of the Northwest in Portland, Oregon	November 1, 2012	0
1C-GF-00-12-030	PacifiCare of Texas, Inc., Plan Code GF in Cypress, California	November 1, 2012	627,859
1C-SW-00-12-025	HealthAmerica Pennsylvania, Inc. in Harrisburg, Pennsylvania	November 1, 2012	0
1A-99-00-12-021	Aging Health Benefit Refunds for a Sample of BlueCross BlueShield Plans in Washington, D.C.	November 6, 2012	225,031
1C-26-00-12-026	HealthAmerica Pennsylvania, Inc. in Pittsburgh, Pennsylvania	November 6, 2012	0
1B-45-00-12-017	Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health for 2009 and 2010 in Northbrook, Illinois	December 13, 2012	0
1A-10-33-12-020	BlueCross BlueShield of North Carolina in Durham, North Carolina	December 27, 2012	387,488
1A-10-67-12-004	BlueShield of California in San Francisco, California	January 10, 2013	221,174
1C-SV-00-12-068	Coventry Health Care of Iowa, Inc. in Omaha, Nebraska	January 10, 2013	0
1A-10-49-12-035	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey	February 5, 2013	230,608
1C-JN-00-12-070	Aetna Open Access – Washington, D.C. Area in Blue Bell, Pennsylvania	February 6, 2013	0
1C-IG-00-12-049	Coventry Health Care, Inc. – Plan Code IG in Columbia, Maryland	February 21, 2013	630, 216
ID-87-00-12-041	Hawaii Medical Service Association in Honolulu, Hawaii	February 21, 2013	479,336
1C-LX-00-12-071	Blue Care Network of Michigan, Inc. in Southfield, Michigan	February 21, 2013	0
IA-99-00-12-055	Global Assistant Surgeon Claim Overpayments for BlueCross and BlueShield Plans	February 21, 2013	1,057,326
1C-GA-00-12-063	MVP Health Care – Eastern Region in Schenectady, New York	February 21, 2013	0



### APPENDIX III

#### Insurance Audit Reports Issued

OCTOBER 1, 2012 TO MARCH 31, 2013

*(Continued)*

Report Number	Subject	Date Issued	Questioned Costs
1C-Q8-00-12-057	Univera Healthcare – Plan Code Q8 in Rochester, New York	March 11, 2013	\$ 578,157
1D-89-00-12-036	Triple-S Salud, Inc. in San Juan, Puerto Rico	March 18, 2013	2,394,593
1A-99-00-12-029	Global Coordination of Benefits for BlueCross and BlueShield Plans	March 20, 2013	4,690,639
1C-F8-00-13-009	Kaiser Foundation Health Plan of Georgia, Inc. in Atlanta, Georgia	March 28, 2013	0
<b>TOTALS</b>			<b>\$11,970,560</b>

### APPENDIX IV

#### Internal Audit Reports Issued

OCTOBER 1, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued
4A-CF-00-12-040	OPM's Fiscal Year 2012 Special-Purpose Financial Statements in Washington, D.C.	November 15, 2012
4A-CF-00-12-039	OPM's Fiscal Year 2012 Consolidated Financial Statements in Washington, D.C.	November 15, 2012
4A-RI-00-12-024	OPM's Oversight of the Federal Flexible Spending Account Program in Washington, D.C.	February 6, 2013
4A-CF-00-13-016	OPM's Fiscal Year 2012 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.	March 11, 2013



## APPENDIX V

### Combined Federal Campaign Audit Reports Issued

OCTOBER 1, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued	Questioned Costs
3A-CF-00-12-047	The 2009 and 2010 Combined Federal Campaigns of Delaware in Wilmington, Delaware	March 4, 2013	\$20,046
3A-CF-00-12-048	The 2009 and 2010 Sun Country Combined Federal Campaigns in El Paso, Texas	March 18, 2013	0
3A-CF-00-12-046	The 2009 and 2010 Overseas Combined Federal Campaigns in Alexandria, Virginia	March 18, 2013	16,301
<b>TOTALS</b>			<b>\$36,347</b>

## APPENDIX VI

### Information Systems Audit Reports Issued

OCTOBER 1, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued
ID-97-00-12-012	Information Systems General and Application Controls at Hawaii Medical Service Association in Honolulu, Hawaii	October 17, 2012
4A-CI-00-12-016	Federal Information Security Management Act Audit FY 2012 in Washington, D.C.	November 5, 2012
ID-80-00-12-045	Information Systems General and Application Controls at EmblemHealth in New York, New York	December 10, 2012
1C-22-00-12-065	Information Systems General and Application Controls at Aetna Inc. in Hartford, Connecticut	March 18, 2013

## APPENDIX VII

### Evaluation Reports Issued

OCTOBER 1, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued
IK-RS-00-12-031	OPM's Voice over Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.	December 12, 2012



## APPENDIX VIII

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

OCTOBER 1, 2012 TO MARCH 31, 2013

Report Number	Subject	Date Issued
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM, in Washington, D.C.; 12 total recommendations; 3 open recommendations	April 16, 2007
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008 in Washington, D.C.; 19 total recommendations; 3 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements in Washington, D.C.; 6 total recommendations; 6 open recommendations	November 14, 2008
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 3 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 5 open recommendations	November 13, 2009
4A-CF-00-10-021	Service Credit Redeposit and Deposit System in Washington, D.C.; 8 total recommendations; 2 open recommendations	January 8, 2010
4A-IS-00-09-060	Quality Assurance Process Over Background Investigations in Washington, D.C.; 18 total recommendations; 3 open recommendations	June 22, 2010
4A-CF-00-10-018	Information Technology Security Controls for OPM's Benefits Financial Management System in Washington, D.C.; 15 total recommendations; 1 open recommendation	September 10, 2010
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 6 open recommendations	November 10, 2010
4A-CF-00-10-047	Information Technology Security Controls for OPM's Annuity Roll System in Washington, D.C.; 13 total recommendations; 1 open recommendation	November 22, 2010
4A-CF-00-10-043	Payroll Debt Management Process for Active and Separated Employees in Washington, D.C.; 8 total recommendations; 5 open recommendations	March 4, 2011
1K-RS-00-11-034	Review of the Payroll Functions Related to the Federal Employees Health Benefits Program Enrollment Transactions for Annuitants in Washington, D.C.; 5 total recommendations; 2 open recommendations	March 14, 2011
4A-CF-00-10-023	OPM's Invoice Payment Process in Washington, D.C.; 3 total recommendations; 1 open recommendation	March 30, 2011
4A-CI-00-11-016	Information Technology Security Controls for OPM's Enterprise Server Infrastructure General Support System in Washington, D.C.; 3 total recommendations; 2 open recommendations	May 16, 2011
1H-80-00-10-062	Group Health Incorporated's Pharmacy Operations in New York, New York; 14 total recommendations; 5 open recommendations	September 8, 2011



## APPENDIX VIII

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

OCTOBER 1, 2012 TO MARCH 31, 2013

*(Continued)*

Report Number	Subject	Date Issued
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 4 open recommendations	September 14, 2011
4A-CI-00-11-009	Federal Information Security Management Act for FY 2011 in Washington, D.C.; 29 total recommendations; 9 open recommendations	November 9, 2011
4A-CF-00-11-050	OPM's FY 2011 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 7 open recommendations	November 14, 2011
1A-99-00-11-022	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	January 11, 2012
1J-OL-00-11-033	Federal Employees Dental and Vision Insurance Program as Administered by OPM in Washington, D.C.; 8 total recommendations; 3 open recommendations	February 1, 2012
1H-01-00-11-011	BlueCross BlueShield's Mail Order Pharmacy Operations as Administered by CVS Caremark in 2006 and 2007 in Scottsdale, Arizona; 5 total recommendations; 3 open recommendations	February 2, 2012
4A-RI-00-12-034	Insecure Password Reset Process on Agency-owned Information Systems in Washington, D.C.; 3 total recommendations; 1 open recommendation	February 7, 2012
1B-31-00-10-038	Government Employees Health Association, Inc. in Lee's Summit, Missouri; 16 total recommendations; 12 open recommendations	March 12, 2012
1C-RL-00-11-042	Grand Valley Health Plan, Inc. in Grand Rapids, Michigan; 2 total recommendations; 2 open recommendations	March 13, 2012
1A-10-00-11-052	Information Systems General and Application Controls at Medco Health Solutions, Inc., in Franklin Lakes, New Jersey; 6 total recommendations; 2 open recommendations	March 14, 2012
4A-RI-00-12-009	OPM's FY 2011 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 4 total recommendations; 3 open recommendations	March 14, 2012
1A-99-00-11-055	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 1 open recommendation	March 28, 2012
4A-CF-00-09-014	OPM's Interagency Agreement Process in Washington, D.C.; 8 total recommendations; 8 open recommendations	March 28, 2012
3A-CF-00-11-036	The 2008 and 2009 Taconic Valley Combined Federal Campaigns in White Plains, New York; 15 total recommendations; 7 open recommendations	April 26, 2012
1C-NV-00-11-047	New West Health Services in Helena, Montana; 2 total recommendations; 2 open recommendations	June 4, 2012





## APPENDIX VIII

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

OCTOBER 1, 2012 TO MARCH 31, 2013

*(Continued)*

Report Number	Subject	Date Issued
1A-99-00-12-001	Global Omnibus Budget Reconciliation Act of 1993 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 4 open recommendations	July 16, 2012
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report and Receivables Tracking System in Washington, D.C.; 24 total recommendations; 24 open recommendations	July 16, 2012
4A-HR-00-12-037	Information Security Posture of OPM's USAJOBS System in Washington, D.C.; 26 total recommendations; 3 open recommendations	July 26, 2012
1H-01-00-11-063	BlueCross BlueShield's Retail Pharmacy Operations as Administered by CVS Caremark in Scottsdale, Arizona; 6 total recommendations; 3 open recommendations	August 8, 2012
1B-31-00-11-066	Information Systems General and Application Controls at Government Employees Health Association, Inc. in Lee's Summit, Missouri; 26 total recommendations; 14 open recommendations	August 9, 2012
4A-CF-00-12-015	Information Technology Security Controls of OPM's Service Credit Redeposit and Deposit System in Washington, D.C.; 9 total recommendations; 7 open recommendations	August 9, 2012
1C-76-00-12-006	Union Health Services, Inc. in Chicago, Illinois; 2 total recommendations; 2 open recommendations	August 20, 2012
4A-CF-00-11-067	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 11 open recommendations	September 13, 2012
4A-HR-00-12-044	USAJOBS System Development Lifecycle in Washington, D.C.; 10 total recommendations; 7 open recommendations	September 28, 2012



## APPENDIX IX

### Most Recent Peer Review Results

OCTOBER 1, 2012 TO MARCH 31, 2013

*We do not have any open recommendations  
to report from our peer reviews.*

Subject	Date of Report	Result
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization (Issued by the Office of Inspector General, Board of Governors of the Federal Reserve System)	September 26, 2012	Pass <sup>3</sup>
Quality Control System Review of the U.S. Department of Commerce's Office of Inspector General Audit Organization (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	July 13, 2012	Pass <sup>3</sup>
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Tennessee Valley Authority (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	December 14, 2010	Compliant <sup>4</sup>
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management (Issued by the Office of Inspector General, U.S. Agency for International Development)	June 2, 2010	Full Compliance <sup>4</sup>

<sup>3</sup>A **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.

<sup>4</sup>A rating of **Compliant** or **Full Compliance** conveys that the reviewed Office of the 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.



# APPENDICES

## APPENDIX X Investigative Recoveries OCTOBER 1, 2012 TO MARCH 31, 2013

OIG Case Number <sup>5</sup>	Case Category	Action <sup>5</sup>	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2011 00062	Federal Investigative Services Fraud	Criminal	\$ 109,000	\$ 109,000	\$ 100
I-12-00309	Federal Investigative Services Fraud	Criminal	38,238	38,238	100
<b>TOTAL</b>	<b>Federal Investigative Services Fraud</b>		<b>\$147,238</b>	<b>\$147,238</b>	<b>\$200</b>
C-12-00745	Health Care Fraud	Administrative	13,061	13,061	0
I 2005 00121	Health Care Fraud	Criminal	0	108,332	2,200
I 2007 00065	Health Care Fraud	Civil	11,573	122,989	0
I 2007 00280	Health Care Fraud	Civil	826,960	30,000,000	0
I 2008 00096	Health Care Fraud	Criminal	0	1,500,000	698,500,125
I 2008 00098	Health Care Fraud	Civil	168,525	15,000,000	0
I 2008 00098	Health Care Fraud	Civil	5,336,406	612,000,000	0
I 2008 00098	Health Care Fraud	Criminal	0	0	150,000,125
I 2008 00425	Health Care Fraud	Civil	0	800,000	0
I 2008 00425	Health Care Fraud	Civil	0	1,500,000	0
I 2009 00128	Health Care Fraud	Civil	4,621,374	95,000,000	0
I 2009 00916	Health Care Fraud	Civil	411,258	22,500,000	0
I 2009 00916	Health Care Fraud	Criminal	0	0	22,500,125
I 2011 00023	Health Care Fraud	Criminal	0	0	1,950
I 2011 00040	Health Care Fraud	Civil	2,468,484	109,000,000	0
I 2011 00575	Health Care Fraud	Civil	438,701	1,572,750	0
I 2011 00783	Health Care Fraud	Civil	0	55,000,000	0
I-12-00099	Health Care Fraud	Criminal	1,623	2,799	200
I-12-00280	Health Care Fraud	Civil	2,820	907,355	0
I-12-00403	Health Care Fraud	Civil	41,652	1,273,126	0
I-12-00709	Health Care Fraud	Civil	4,211	134,144	0
I-13-00072	Health Care Fraud	Civil	107,710	4,900,704	0
<b>TOTAL</b>	<b>Health Care Fraud</b>		<b>\$14,454,357</b>	<b>\$951,335,260</b>	<b>\$871,004,725</b>
I 2011 00063	Combined Federal Campaign Fraud	Criminal	31,283	990,366	200
<b>TOTAL</b>	<b>Combined Federal Campaign Fraud</b>		<b>\$ 31,283</b>	<b>\$ 990,366</b>	<b>\$ 200</b>



**APPENDIX X**  
**Investigative Recoveries**  
 OCTOBER 1, 2012 TO MARCH 31, 2013

(Continued)

OIG Case Number <sup>5</sup>	Case Category	Action <sup>5</sup>	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2007 00090	Retirement Fraud	Criminal	\$ 161,757	\$ 222,641	\$ 1,300
I 2010 00053	Retirement Fraud	Criminal	67,850	67,850	25
I 2010 00059	Retirement Fraud	Criminal	191,303	191,303	100
I 2010 00080	Retirement Fraud	Criminal	98,044	98,044	100
I 2010 00963	Retirement Fraud	Civil	74,405	74,405	0
I 2011 00064	Retirement Fraud	Criminal	116,911	116,911	25
<b>TOTAL</b>	<b>Retirement Fraud</b>		<b>\$710,271</b>	<b>\$771,155</b>	<b>\$1,550</b>
<b>GRAND TOTAL</b>			<b>\$15,343,149</b>	<b>\$953,244,019</b>	<b>\$871,006,675</b>

<sup>5</sup>Cases that are listed multiple times indicate there were multiple subjects.



# OFFICE OF THE INSPECTOR GENERAL

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