



SEMIANNUAL REPORT TO CONGRESS

April 1, 2016 – September 30, 2016

United States
Office of Personnel Management
OFFICE OF THE INSPECTOR GENERAL

OFFICE OF THE INSPECTOR GENERAL



INDICATORS

Financial Impact:

| | |
|--|--------------|
| Audit Recommendations for Recovery of Funds. | \$18,726,283 |
| Management Commitments to Recover Funds. | \$15,591,919 |
| Recoveries Through Investigative Actions. | \$5,274,843 |

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 | 26 |
| Evaluation Reports Issued | 1 |
| Investigative Cases Closed | 26 |
| Indictments and Informations. | 28 |
| Arrests | 18 |
| Convictions | 14 |
| Hotline Contacts and Preliminary Inquiries Complaints Received | 1,409 |
| Hotline Contacts and Preliminary Inquiries Complaints Closed | 2,318 |
| Health Care Provider Debarments and Suspensions | 547 |
| Health Care Provider Debarment and Suspension Inquiries. | 2,448 |



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MESSAGE FROM THE DEPUTY INSPECTOR GENERAL

In 1952, Congress transferred the responsibility for background checks of potential civil servants from the Federal Bureau of Investigation (FBI) to what is now the U.S. Office of Personnel Management (OPM). The reasoning behind this transfer was that it was an inefficient use of the FBI's law enforcement resources to investigate applicants for civil service positions. Given the agency's role in promulgating the rules and regulations governing Federal employment, it made sense for OPM to also conduct background investigations to assist agencies in determining whether an individual was suitable for such work.

Over the years, OPM's background investigations program has changed drastically even though operationally, the work remained essentially the same. In 1996, the function was privatized in hopes of achieving greater efficiency. This resulted in the organization of a company named USIS, which remained OPM's largest background investigations contractor for the next 20 years.

Prior to 2003, a U.S. Department of Defense (DOD) component, the Defense Security Service (DSS), performed all background investigations for DOD employees. However, DSS was plagued with a massive backlog of cases causing harmful delays in issuing security clearances. Further, both the DOD Office of Inspector General (OIG) and the Government Accountability Office issued multiple reports documenting various problems with DOD's management and oversight of the program. In 2003, concern about these findings prompted Congress to transfer DSS's Background Investigations Service Division's functions and personnel to OPM, thereby consolidating in one agency the background investigations operations for 95 percent of the Federal Government.

Over the next decade, OPM conducted background investigations using a mix of Federal employees and contractors. USIS remained by far OPM's largest background investigations contractor – indeed, it held not just a contract to perform fieldwork (such as conducting interviews), but also one to perform various support services, including conducting a final review of cases submitted by fieldwork contractors.

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In January 2014, based upon an investigation conducted by the OPM OIG, the U.S. Department of Justice filed a False Claims Act suit against USIS. The Government alleged that between 2008 and 2012, approximately 40 percent of the background investigations submitted by USIS to OPM under the fieldwork contract had not undergone the contractually required quality review. Further, OIG criminal investigators found evidence suggesting that USIS employees working under the fieldwork contract colluded with USIS employees under the support services contract to ensure that OPM did not discover the fraud.

Later that year, in September 2014, OPM opted to not renew either of its contract with USIS. The company filed for bankruptcy in June 2015, and two months later agreed to forgo \$30 million in payments owed to it by OPM in order to settle the False Claims Act suit.

In 2015, the background investigations program was thrust into the national spotlight when it was revealed that the associated information technology (IT) systems had been hacked and the personal information of 22 million Federal employees, contractors, and their families had been compromised. For years the OPM OIG had issued audit reports identifying various red flags in OPM's IT security posture, and those reports generated substantial interest on the part of Congressional committees. The President tasked the Suitability and Security Performance Accountability Council to conduct a 90-day review to examine IT security and other issues related to the background investigations process. The result of this review would be the most significant change in the background investigations program since its inception in 1952.

In January 2016, the President announced that he would create a new, semi-autonomous entity within OPM that would conduct not only the agency's existing background investigations operations, but also engage in a range of additional activities. On September 29, 2016, the President signed an executive order creating this new organization, the National Background Investigations Bureau (NBIB).

By all accounts, the NBIB appears to be constructed around two basic principles: (1) information sharing across Federal, state, and local governments is critical to conducting quality background investigations, and (2) the agency must have cutting edge IT systems and tools to facilitate such coordination and cooperation. In pursuit of the first goal, the President decreed that for the first time, the head of OPM's background investigations program would be a Presidential appointee and a member of the Performance Accountability Council. To achieve the second goal, the President decided to leverage DOD's IT security expertise and make the department responsible for building, securing, and maintaining all of the NBIB IT systems.

As fiscal year 2017 begins, OPM is facing challenges and obstacles unlike any that it has seen in the past. Creating a new Government entity is a daunting task under the very best of circumstances, let alone when faced with a ballooning backlog of cases while living in a world where we are all under constant attack by smart and innovative cyber adversaries. Poor planning can have severe repercussions for the agency's success for years or decades to come. It is moments like this – when so very much is at stake – that objective, independent oversight is most crucial.

To that end, we here at the OPM OIG would like to reassure Congress and the American taxpayers that we will continue to conduct thorough, objective oversight of NBIB that meets the highest professional standards and protects the integrity of its programs. There is much at stake with the creation of the NBIB, and we hope that the top management officials at OPM and the NBIB will use our work as a resource that will inform the critical decisions they will make regarding the background investigations program in the coming years.



Norbert E. Vint

Deputy Inspector General



MISSION STATEMENT

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

We accomplish our mission by:

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

Guiding Principles

We are committed to:

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

Strategic Objectives

The 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), as well as through the marketplaces under the Affordable Care Act. Our office is responsible for auditing the activities of these programs 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 275 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 carrier mergers and acquisitions. The premium payments for these health insurance programs are over \$50.3 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) or health plans.

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

Community-rated and experience-rated carriers differ in the level of risk each type of carrier assumes. Community-rated carriers must pay claims and cover their costs from the premiums they receive each year. If the premiums are not sufficient to cover the costs, the community-rated carriers suffer the loss. Experience-rated carriers request reimbursement for actual claims paid, administrative expenses incurred, and service charges for administering a specific contract from the Letter-of-Credit account, which is not solely dependent on total premiums paid to the carrier during the year.

During the current reporting period, we issued 16 final audit reports on organizations participating in the FEHBP, of which 10 contain recommendations for monetary adjustments in the amount of \$18.7 million due to the OPM-administered trust funds.

COMMUNITY-RATED PLANS

The community-rated carrier audit universe covers approximately 150 health plans located throughout the country. Community-rated audits are designed to ensure that the premium rates health plans charge the FEHBP are in accordance with their respective contracts and applicable Federal laws and regulations.

Similarly Sized Subscriber Group Audits

Federal regulations effective prior to July 2015 require that the FEHBP rates be equivalent to the rates a health plan charges the two employer groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups (SSSGs)*. The rates are set by the health plan, which is also responsible for selecting the SSSGs. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

Similarly sized subscriber group audits of traditional community-rated carriers focus on ensuring that:

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

A Loading is a rate adjustment that participating carriers add to the FEHBP rates to account for additional benefits not included in its basic benefit package.

Medical Loss Ratio Audits

In April 2012, OPM issued a final rule establishing an FEHBP-specific Medical Loss Ratio requirement (MLR) to replace the SSSG comparison requirement for most community-rated FEHBP carriers.

Medical Loss Ratio (MLR) is the proportion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected. The MLR is important because it requires health insurers to provide consumers with value for their premium payments.

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state mandated to use traditional community rating. State mandated traditional community rating carriers continue to be subject to the SSSG comparison rating methodology, which was amended in 2015 to require only one rather than two SSSGs.

Starting with the pilot program in 2012 and for all non-traditional community rating FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. The FEHBP-specific MLR required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due. Since the claims cost is a major factor in the MLR calculation, we are now focusing our efforts on auditing the FEHBP claims used in the MLR calculation.

Multi-State Plan Program Audits

The Multi-State Plan Program (MSP Program) was established by Section 1334 of the Affordable Care Act. Under the Affordable Care Act, OPM was directed to contract with private health insurers to offer Multi-State Plan (MSP) products in each state and the District of Columbia. OPM negotiates contracts with



MSP Program Issuers, including rates and benefits, in consultation with states and marketplaces. In addition, OPM monitors the performance of MSP Program Issuers and oversees compliance with legal requirements and contractual terms. OPM's office of National Healthcare Operations has overall responsibility for program administration. In 2016, the MSP Program universe consists of approximately 40 state-level issuers covering 33 states and the District of Columbia. Our audits of this program test the issuer's compliance with the provisions of its contract with OPM as well as with other applicable Federal regulations.

During this reporting period, we issued 6 final audit reports on community-rated health plans and MSP issuers and recommended approximately \$888,000 in recoveries. Because there is no money involved in the MSP Program contract, these recoveries cannot be returned to the FEHBP. Report summaries are provided below to highlight notable audit findings.

Aetna Open Access – Athens and Atlanta

BLUE BELL, PENNSYLVANIA
Report No. 1C-2U-00-15-030
 MAY 10, 2016

The Aetna Open Access Plan - Athens and Atlanta (Plan) has participated in the FEHBP since 1983, and provides health benefits to FEHBP members in the Athens and Atlanta, Georgia areas. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-

up and MLR submissions. During this period, the FEHBP paid the Plan approximately \$98 million in premiums.

Our auditors questioned \$766,267 for an MLR penalty underpayment in 2013. Although there are findings related to the 2012 MLR calculation, these findings resulted in no penalty due for this contract year.

**Errors in the
 2013 MLR
 Calculation
 Result in a
 \$766,267
 Penalty
 Underpayment
 to OPM**

Specifically, we found that the Plan:

- Did not use a fair and equitable allocation method to derive the FEHBP's portion of Federal income tax expense; and,
- Overstated the medical and pharmacy claims, used to derive the 2013 MLR, by including payments to ineligible members.

Aetna agreed with the claim overpayments and updated their MLR calculation accordingly. However, it does not agree with our finding regarding its income tax allocation methodology. As this particular issue will impact audits of other plans Aetna administers, it is crucial that OPM develop program guidance to more clearly define acceptable allocation methods. OPM is still in the process of resolving this audit.

Aetna Open Access – Northern New Jersey

BLUE BELL, PENNSYLVANIA
Report No. 1C-JR-00-15-046
 JULY 15, 2016

The Aetna Open Access Plan – Northern New Jersey (Plan) has participated in the FEHBP since 2002, and provides health benefits to FEHBP members in Northern New Jersey. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-up and MLR submissions. During this period, the FEHBP paid the Plan approximately \$104 million in premiums.

Although our auditors identified findings related to the 2012 and 2013 MLR calculations, these findings resulted in no penalty due for these contract years.

Specifically, we found that the Plan:

- Used "Direct Premiums Written" instead of "Direct Premiums Earned" to determine the large group premium ratio. "Direct Premiums Earned" more accurately represents the calendar year premium;
- Did not use a fair and equitable allocation method to derive the FEHBP's portion of Federal income tax expense; and,
- Overstated the medical and pharmacy claims, used to derive the 2013 MLR, by including payments for non-covered benefits.



Aetna agreed with the claim overpayments and has developed a corrective action plan to address these issues going forward. However, it does not agree with the remaining audit issues, although Aetna has also developed a potential corrective action plan to address the “Direct Premiums Written” versus “Direct Premiums Earned” finding starting with audits covering contract year 2014. The remaining finding regarding Aetna’s income tax allocation methodology is still in the process of being resolved. However, as this particular issue will impact audits of other plans Aetna administers, it is crucial that OPM develop program guidance to more clearly define acceptable allocation methods. OPM is still in the process of resolving this audit.

BlueCross BlueShield of Texas

CHICAGO, ILLINOIS

Report No. 1M-OD-00-16-001

SEPTEMBER 28, 2016

The BlueCross BlueShield Association, on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a contract with OPM to participate in the MSPP. Along with its participating licensees, the Association offers 154 MSP options in 30 states and the District of Columbia. BlueCross BlueShield of Texas (BCBSTX) was one of 35 BCBS plans, or State-Level Issuers, participating in the MSP Program in 2014.

BCBSTX is a subsidiary of the Health Care Service Corporation (HCSC). HCSC is the largest customer-owned health insurance company in the United States and offers a variety of health insurance products through its operating divisions and subsidiaries. In addition to offering the MSP options on the Federal marketplace, BCBSTX offers other individual and family health plans, dental plans, and Medicare supplement plans.

The audit covered BCBSTX’s compliance with the 2014 Contract and applicable regulations. Our auditors identified six areas of non-compliance and recommended an area for program improvement.

Specifically, we found that BCBSTX did not:

- Have formal termination policies and procedures in 2014;
- Process the termination of enrollee coverage for 36 MSP members in accordance with the 2014 Contract and applicable regulations;
- Process one 2014 enrollment fallout work item timely;
- Adequately support one 2014 MSP Health Insurance Casework System case;
- Meet the claims processing accuracy standard required by the 2014 Contract; and,
- Meet the enrollment processing timeliness standard required by the 2014 Contract.

Areas of Non-compliance with OPM’s Contract Result in a Lack of Efficiency and Effectiveness in the Enrollment and Termination of MSPP Members, as well as in the Accurate Processing of MSPP Claims.

Finally, to improve program performance, our auditors recommended that BCBSTX update its benefit brochure language related to termination of coverage to more accurately reflect the process and timing of the termination notices.

BCBSTX agreed with most of the audit findings and our recommendation for program improvement and proposed corrective actions to address them. Until such time that we can confirm that these corrective actions adequately address the audit issues, however, the audit remains open.

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 health benefit refunds and drug rebates;
- Effectiveness of carriers' claims processing, financial, cost accounting and cash management systems; and,
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During this reporting period, we issued four experience-rated final audit reports. Our experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, cash management activities, and/or fraud and abuse program activities. In these reports, our auditors recommended that the plans return \$14.1 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

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 underwrite and 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 an overall accounting for 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 64 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued three BCBS experience-rated reports during the reporting period. Our auditors identified \$10 million in questionable costs charged to the FEHBP contract. Summaries of these final reports are provided on pages 9 – 14 (as part of the Information Systems Audits) to highlight our notable audit findings.

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, the 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 coverage 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 one experience-rated comprehensive medical plan audit report during this reporting period, which is highlighted below.

Group Health Incorporated

NEW YORK, NEW YORK

Report No. 1D-80-00-15-044

JUNE 13, 2016

Group Health Incorporated (Plan) is an experience-rated HMO offering High and Standard Option plans to Federal enrollees and their families. Plan enrollment is open to all Federal employees and annuitants that live or work in the Plan's service area, which includes New York and the surrounding counties in Northern New Jersey.

Our audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits (such as refunds, fraud recoveries, pharmacy and medical drug rebates, and hospital settlements) and administrative expense charges from 2010 through 2014. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from 2010 through 2014, and the Plan's fraud and abuse program for 2014 through March 2015. Due to concerns with the Plan's medical drug rebates and working capital funds, we expanded our audit scope for these items to also include January 2015 through September 2015. For contract years 2010 through 2014, the Plan processed approximately \$1.1 billion in FEHBP health benefit payments and charged the FEHBP \$97 million in administrative expenses for this experience-rated HMO.

We questioned \$4,077,394 in health benefit charges, administrative expense overcharges, cash management activities, and Lost Investment Income (LII); and our auditors identified a procedural finding regarding the Plan's fraud and abuse program. The monetary findings included the following:

- \$3,487,040 in excess FEHBP funds held by the Plan in the dedicated FEHBP investment account as of September 30, 2015;
- \$249,133 for administrative expense overcharges related to Affordable Care Act fees and \$3,349 for applicable LII on these overcharges;
- \$230,025 for unreturned pharmacy and medical drug rebates and fraud recoveries; and,
- \$107,847 for LII on health benefit refunds and recoveries, pharmacy and medical drug rebates, and fraud recoveries returned untimely to the FEHBP.

For the procedural finding regarding the Plan's fraud and abuse program, we determined that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters. Specifically, the Plan did not report, or report timely, all fraud and abuse cases to OPM's OIG. Without notification of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

Group Health Incorporated Returned Over \$4 Million in Questioned Amounts to the FEHBP

The Plan agreed with our monetary findings and returned all of the questioned amounts to the FEHBP. Although the Plan disagreed with our procedural finding, the Plan has implemented the necessary procedural changes to meet the communication and reporting requirements of fraud and abuse cases that are contained in FEHBP Carrier Letter 2014-29.



Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems assist in the management of background investigations for Federal employees, the processing of retirement benefits, and multiple Government-wide human resources services. OPM also contracts with private industry health insurance carriers to administer programs that distribute health benefits to millions of current and former Federal employees. The increasing frequency and sophistication of cyber-attacks on both the private and public sector emphasizes the need for OPM and its contractors to implement and maintain effective cybersecurity programs. Our information technology audits outline areas for improvement in the auditee’s cybersecurity posture and our recommendations provide tangible strategies to remediate those weaknesses.

Our audit universe encompasses all OPM-owned information systems as well as the information systems used by any private sector entity that contracts with OPM to process Federal data. In addition, our auditors evaluate historical health benefit claims data for appropriateness, and make audit recommendations that erroneous payments be returned to OPM.

Several of the more notable audit reports issued during this period are summarized below.

Second Interim Status Report on OPM’s Infrastructure Improvement Project – Major IT Business Case

WASHINGTON, D.C.

Report No. 4A-CI-00-16-037

MAY 18, 2016

We issued a second interim status report that discusses the events that have transpired since the OIG’s September 3, 2015 Interim Status Report, as they apply to the concerns outlined in the initial June 17, 2015, Flash Audit Alert – OPM’s Infrastructure Improvement Project.

OPM has still not performed many of the critical capital project planning practices required by the Office of Management and Budget (OMB). Of primary concern, prior to initiating the Infrastructure Improvement Project (Project), OPM did not perform the mandatory Analysis of Alternatives to evaluate

whether moving its entire technical infrastructure and all applications to a new environment (initially known as Shell, but now referred to as IaaS [Infrastructure as a Service]) was the best solution to address the stated objective of this initiative: to provide a secure operating environment for OPM systems at a lower cost. In light of recent developments involving the creation of the National Background Investigations Bureau (NBIB) within OPM to replace the Federal Investigative Services (FIS), the current Federal background investigations program, and the shifting of the responsibility for developing and maintaining the associated information technology (IT) systems to the Department of the Defense, this analysis is even more important. In addition, most, if not all, of the supporting project management activities required by OMB have still not been completed.

Furthermore, the estimated lifecycle costs of the Project are unsupported by any detailed technical analysis of the level of effort needed to modernize OPM systems and migrate them to the IaaS platform. However, OPM has made strides in identifying the inventory of its IT systems being moved to the new environment, and performing a risk analysis to determine the timing of modernization and migration activities.

Critical Capital Project Planning Practices Required by OPM Still not Performed by OPM



BlueCross BlueShield of Alabama

BIRMINGHAM, ALABAMA

Report No. 1A-10-09-15-043

JUNE 8, 2016

The objectives of our audit were to determine whether BCBS of Alabama charged costs to the FEHBP

FEHBP Overcharged \$24,332 for Claims not Properly Discounted in Patients Who Received Multiple Services

and provided services to FEHBP members in accordance with the terms of its contract with OPM. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to claim payments.

We reviewed the BCBS Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements as they pertain to BCBS of Alabama for contract years 2012 through 2015.

Our audit identified several minor incidents of erroneous claim payments, but we do not believe that the errors are indicative of major systemic control problems. Therefore, we concluded the Plan's processing of FEHBP claims appears to be in compliance with the terms of its contract with OPM and industry standards. The report questions \$24,332 in health benefit charges. The majority of the questioned charges are the result of claim payments that should have been subject to a discount because the patient received multiple services in a single day.

Audit of Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-15-047

JUNE 17, 2016

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the contract with OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to claims paid in accordance with the Omnibus Budget Reconciliation Act of 1990 (OBRA 90).

The audit covered health benefit payments from January 1, 2012 through April 30, 2015, as reported in the BCBS Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements.

Our audit identified several erroneous claim payments that we believe are indicative of minor systemic control problems. Although the Association generally has adequate procedures in place to properly price and pay OBRA 90 claims, we identified two system enhancements that would result in a cost savings to the FEHBP.

BCBS Erroneously Paid \$9.9 Million in OBRA 90 Claims

The report questioned \$9,937,273 in health benefit charges.

Information Systems General and Application Controls at Wellmark Inc. BlueCross BlueShield

DES MOINES, IOWA
 Report No. 1A-10-31-15-058
 JUNE 17, 2016

Our IT audit focused on the claims processing applications used to adjudicate FEHBP claims, as well as the various processes and IT systems

used to support these applications.

Security Controls are in Compliance; However, Minor Control Weaknesses Noted for Implementation

Our audit identified several minor control weaknesses where Wellmark could implement additional IT security controls or improve upon existing controls. However, we do not believe that these issues are indicative of systemic control

problems, and we concluded that Wellmark generally has a comprehensive and mature IT security program in place. Specifically, we determined that Wellmark has:

- Established an adequate security management program;
- Implemented controls to prevent unauthorized physical access to its facilities, as well as logical controls to protect sensitive information;
- Implemented an incident response and network security program. However, Wellmark does not have an adequate methodology in place to ensure that unsupported or out-of-date software is not utilized;
- The systems used to process FEHBP claims for Wellmark had edits in place to catch many of our test claims, but could potentially benefit from additional controls related to medical edits and patient history;

- Implemented a configuration management program with documented program and change management policies including baseline standards for operating platforms; and,
- Established a risk-based contingency planning program including multiple plans and regular testing of its plans.

Information Systems General and Application Controls at CACI International, Inc.

CHANTILLY, VIRGINIA
 Report No. 6A-0A-00-16-004
 JULY 21, 2016

CACI International, Inc. (CACI) is a service contractor for OPM's FIS. The Investigation and Managements Service Division (IMSD) within CACI supports OPM's FIS, which is responsible for helping to ensure that the Federal Government has a workforce that is worthy of the public trust by providing both suitability and security clearance determinations.

We performed an IT audit focused on the CACI and IMSD information systems that process and/or store Federal data, as well as the various processes and IT systems used to support these systems.

We documented the controls in place and opportunities for improvement in each of the areas below.

Security Management

Nothing came to our attention to indicate CACI and IMSD do not have adequate security management programs.

Access Controls

IMSD has implemented controls to prevent unauthorized physical access to its facilities, as well as logical controls to protect sensitive information. However, we noted that the controls related to removing logical access for terminated employees could be improved. In addition, IMSD could benefit from adding additional controls related to routinely auditing user access privileges to ensure they remain appropriate.



Network Security

IMSD could improve its network security program by routinely performing firewall configuration reviews.

Configuration Management

IMSD has implemented a configuration management process to control changes made to its IT systems, and leverages publicly available configuration baseline standards as a guideline to securely configure its servers. However, IMSD has not formally documented deviations/exceptions to these public standards, and does not perform routine configuration audits to ensure that servers are actually in compliance with approved baseline standards.

Contingency Planning

IMSD's business continuity and disaster recovery plans contain the elements suggested by relevant guidance and publications. IMSD has identified and prioritized the systems and resources that are

critical to business operations, and has developed detailed procedures to recover those systems and resources.

Application Controls

IMSD has implemented multiple controls surrounding the input, processing, and output of sensitive data related to the background investigations it performs for

OPM. However, when making changes to applications, the person responsible for migrating changes into the production environment also has access to the development and test environments. This situation constitutes a segregation of duties violation.

Areas for Improvement Noted for CACI's Access Controls, Network Security, Configuration Management and Application Controls

Improvements Still Needed for Network Security and Configuration Management

Information Systems General and Application Controls at Anthem BlueCross BlueShield

INDIANAPOLIS, INDIANA

Report No. 1A-10-62-16-003

AUGUST 15, 2016

Our IT audit focused on the claims processing applications used to adjudicate FEHBP claims for Anthem BCBS (Anthem) members, as well as the various processes and IT systems used to support these applications. This engagement was a follow-up audit where we performed test work that we were restricted from completing during a prior audit of Anthem (Report No. 1A-10-00-13-012).

We documented the controls in place and opportunities for improvement in each of the areas below.

Network Security

Anthem has implemented an incident response and network security program. Anthem has also implemented preventive controls at the network perimeter and performs security event monitoring throughout the network. However, we noted several areas of concern related to Anthem's network security controls:

- Anthem's computer server and database inventories revealed that Anthem has numerous servers running unsupported versions of operating systems.
- Our vulnerability assessment identified numerous servers containing vulnerabilities such as missing patches, noncurrent software, and weak configuration settings. The vast majority of the servers containing vulnerabilities were inherited from a separate company that was recently acquired by Anthem. These servers were migrated into Anthem's network before they were fully integrated into Anthem's vulnerability management, patching, and configuration management programs.



Configuration Management

Anthem has developed formal configuration management policies, has documented security configuration settings for its operating platforms, and performs routine configuration compliance auditing.

**BlueCross BlueShield
of Massachusetts**

BOSTON, MASSACHUSETTS

Report No. 1A-10-11-15-056

AUGUST 15, 2016

The objectives of our audit were to determine whether BCBS of Massachusetts charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract with OPM. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to claim payments.

We reviewed the BCBS Association’s Government-wide Service Benefit Plan FEP Annual Accounting Statements as they pertain to BCBS of Massachusetts for contract years 2012 through 2015.

**FEHBP
Overcharged
\$83,805 for
Multiple Claim
Payments**

Our audit identified several minor incidents of erroneous claim payments, but we do not believe that the errors are indicative of major systemic control problems. Therefore, we concluded that the Plan’s processing of FEHBP claims appears to be in compliance with the terms of its contract with OPM and industry standards. The report questions \$83,805 in health benefit charges.



Internal 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 Act (CFO) of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

OPM's FY 2015 Improper Payments Reporting

WASHINGTON, D.C.

Report Number 4A-CF-00-16-026

MAY 11, 2016

On July 22, 2010 and January 10, 2013, the President signed into law the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), respectively, which amended the Improper Payments Information Act of 2002. IPERIA redefined the definition of "significant improper payments" and strengthened executive branch agency reporting requirements.

The U.S. Office of Management and Budget (OMB) requires agency Inspectors General to review their agency's Agency Financial Report (AFR) for compliance with IPERIA reporting requirements.

The IPERIA criterion for compliance includes requiring agencies to:

- Publish an AFR or Performance and Accountability Report (PAR) for the most recent FY and post that report and any accompanying materials required by OMB on the agency website;
- Conduct a program specific risk assessment for each program or activity that conforms with Section 3321 note of Title 31 United States Code (if required);
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment (if required);
- Publish programmatic corrective action plans in the AFR or PAR (if required);

- Publish and meet annual reduction targets for each program assessed to be at risk and estimated for improper payments (if required and applicable); and,
- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR or PAR.

We conducted a performance audit to determine if OPM's improper payment reporting in the FY 2015 AFR complied with IPERIA requirements. As a result, we found that OPM was not in compliance with two out of six IPERIA requirements for FY 2015.

OPM is not in Compliance with IPERIA Requirements for FY 2015

Risk Assessment

- OPM's risk assessment methodology did not include all nine required risk factors and the scoring methodology for the risk assessments contained errors.
- OPM was unable to support the risk assessment results due to no or insufficient documentation.

Improper Payment Estimate

- OPM did not properly categorize the root causes of the retirement benefits program's improper payments in OPM's FY 2015 AFR.

In addition, we identified an area where OPM can improve on its oversight controls over improper payments reporting. Improper payments information in the AFR was inaccurately reported. Specifically, we identified several inaccuracies between what was reported in an FY 2015 AFR Table 14 and the supporting documentation that we obtained from the program office.



Audit of OPM's Federal Investigative Services' Adjudications Group

WASHINGTON, D.C.

Report Number 4A-IS-00-15-054

JUNE 17, 2016

Our auditors conducted a performance audit of OPM's FIS's Adjudications Group. The objectives of our audit were to determine whether FIS's Adjudications Group:

- Is properly adjudicating cases according to their procedures;
- Has adequate oversight controls over their random review process;
- Has controls in place to ensure that their personnel are trained to perform their duties; and,
- Is in compliance with the Intelligence Reform and Terrorism Prevention Act of 2004 timeliness standards.

FIS conducts approximately 95 percent of all personnel background investigations for the Federal government. Federal agencies use the background reports of investigations, conducted by FIS, to determine an individual's suitability or fitness for Federal civilian, military, and Federal contract employment, as well as their eligibility for access to national security classified information and Federal facilities and information systems. In addition, FIS provides investigative systems training and conducts oversight evaluations of other agencies to review compliance with Federal security regulations.

The FIS Adjudications Group is responsible for:

- Protecting the interests of the Federal Government by taking suitability actions¹ when serious issues² are raised about the character and conduct of competitive service Federal applicants and employees, as a result of a background investigation or agency referral.
- Overseeing all FIS suitability decisions and activities including Applicant Suitability Determinations and Qualifications Fraud Investigations.

¹Suitability Actions are outcomes which may include cancellation of eligibility; removal/cancellation of reinstatement eligibility and debarment described in 5 CFR 731.204 and 205 and may be taken only by OPM or an agency with delegated authority.

²Serious suitability issues are issues dealing with misconduct or negligence in employment; criminal or dishonest conduct; material intentional falsification; refusal to furnish testimony; alcohol abuse or illegal use of drugs without evidence of substantial rehabilitation; knowing and willful engagement in acts or activities designed to overthrow the U.S. Government by force; or statutory or regulatory bars preventing lawful employment.

- Assisting the Office of General Counsel in processing appeals involving unfavorable OPM suitability decisions to the Merit Systems Protection Board.
- Providing materials and instructors for OPM suitability training courses.
- Ensuring FIS contract employees are properly investigated and meet fitness and national security requirements to perform work for or on behalf of FIS.

The results of our audit showed that FIS has effective internal controls over its adjudication process. The FIS Adjudications Group is following its procedures for adjudicating cases, has adequate oversight controls over their random review process, has controls in place to train their personnel, and is in compliance with the Intelligence Reform and Terrorism Prevention Act of 2004 timeliness standards.

FIS Has Effective Controls Over the Adjudications Process

Audit of the OPM's Office of Procurement Operations' Contract Management Process

WASHINGTON, D.C.

Report Number 4A-CA-00-15-041

JULY 8, 2016

Our auditors conducted a performance audit of OPM's Office of Procurement Operations' (OPO) contract management process. Our audit objectives were to:

- Assess the internal controls over the OPO's post-award management process and determine if OPO was deobligating contract funds, according to the Federal Acquisition Regulation (FAR).
- Analyze the Calyptus Consulting Group's independent strategic assessment report and determine if recommendations were valid for procurement compliance, procurement oversight, and acquisition certification and training.



- Determine if the OPO was promptly reporting, investigating and referring suspension and debarment cases, according to the FAR and its internal policies and procedures.

OPO Failed to Initiate the Closeout Process for Over \$108 Million in Open Contract Obligations

The suspension and debarment program was implemented to impose suspension and debarment actions to protect the Government’s interest.

OPO is responsible for awarding and managing the life of a contract through the periods before, during and after award, including contract closeout. In addition, OPO is responsible for OPM’s suspension and debarment program. The suspension and

We determined that OPM needs to strengthen its controls over its contract management process. Specifically, we found:

- OPO did not have strong internal controls over procurement compliance, procurement oversight, workload and staffing, and acquisition certification and training operations.
- For 22 out of 60 contracts we reviewed, the contract amounts reported in the Consolidated Business Information System differed from the contract amounts reported in OPO’s contract files. In addition, OPO was unable to provide 17 out of 60 contract files for our review.
- OPO could not provide a listing of contract closeouts for FYs 2013 and 2014. In addition, for 60 contracts we reviewed, we identified 46 where OPO did not initiate the contract closeout process.

OPO concurred with all six of our recommendations.



Special Audits

In addition to health insurance and retirement programs, OPM administers various other benefit programs for Federal employees which include the: Federal Employees' Group Life Insurance (FGLI) 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, and audits of Tribal enrollments into the FEHBP.

During this reporting period we issued four final audit reports and two FEDVIP rate proposal audit memorandums. The four audits are summarized below.

OPM's Administration of the Federal Employees Dental and Vision Insurance Program for FYs 2010 through 2013

WASHINGTON, D.C.

Report No. 4J-0L-00-15-038

JUNE 3, 2016

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004, Public Law 108-496, 118 Stat. 4001, was signed into law on December 23, 2004. It provided for the establishment of programs under which supplemental dental and vision benefits were made available to Federal employees, retirees, and their dependents.

OPM has the overall responsibility to maintain the FEDVIP website, act as a liaison and facilitate the promotion of the FEDVIP through Federal agencies, provide timely responses to carrier requests for information and assistance, and perform functions typically associated with insurance commissions, such as the review and approval of rates, forms, and educational materials.

The main objective of this audit was to obtain reasonable assurance that OPM's administration of the FEDVIP was compliant with Federal regulations and the provisions of the FEDVIP Solicitation, which is incorporated in each agreement between OPM and the individual FEDVIP Carriers, and that monies received by OPM from the FEDVIP carriers were used only for program purposes.

Our audit identified the following deficiencies for (FY) 2010 through 2013, unless otherwise stated:

- The FEDVIP was overcharged \$127,229 as a result of the lack of sufficient documentation and oversight of FEDVIP expenses on the part of OPM's Office of the Chief Financial Officer (OCFO) and Federal Employee Insurance Operations (FEIO). This was also a finding in our previous audit (Report #1J-0L-00-11-033 dated February 1, 2012);
- In FY 2013, the OCFO inadvertently permitted an unbalanced journal entry, resulting from the change of accounting systems, to remain in the accounting records of the FEDVIP Trust Fund; and,

**Auditors
Questioned
\$127,229 Due
to a Lack of
Sufficient
Documentation
for FEDVIP
Expenses**

- The OCFO did not perform financial viability reviews of the FEDVIP carriers' annual certified financial statements.

In addition, we also identified two opportunities for program improvement in areas related to the FEDVIP loading for OPM's administrative costs and the review and approval of non-labor expenses by the FEIO.

Federal Employees Health Benefits Program Pharmacy Operations as Administered by BlueShield of California Access+ HMO for Contract Years 2011 through 2013

SAN FRANCISCO, CALIFORNIA

Report No. 1H-03-00-15-045

JULY 19, 2016

OPM entered into a contract with BlueShield of California (BSC) to provide health insurance benefits, including prescription drug coverage, to enrollees under the FEHBP plan. BSC is an experience-rated Health Maintenance Organization offering benefits to Federal employees and retirees in the Southern California region. Section 1.6 of the contract includes a provision which allows for audits of the program's operations.

The primary objective of the audit was to determine whether pharmacy costs charged to the

FEHBP and services provided to its members were in accordance with the contract and applicable Federal regulations.

We determined that the Plan needs to strengthen its procedures and controls related to dependent eligibility and the reporting of pharmacy claims. Specifically, our audit identified the following two deficiencies that require corrective action. The Plan:

1. Paid \$12,748 in pharmacy claims for 11 dependents age 26 and older whose eligibility to participate in the FEHBP could not be supported; and,

2. Overstated pharmacy claims paid by \$2,974,655 in its 2011 through 2013 annual accounting statements due to it inappropriately including ancillary and other medical charges under pharmacy benefits.

Federal Employees' Group Life Insurance Program as Administered by Metropolitan Life Insurance Company for FYs 2013 and 2014

BRIDGEWATER, NEW JERSEY AND
ORISKANY, NEW YORK

Report No. 2A-II-00-16-016

AUGUST 10, 2016

In August 1954, The Federal Employees' Group Life Insurance Program (FEGLI) was established by the Federal Government to provide term life insurance to Federal employees, annuitants, and their family members. Under contract with OPM, the Metropolitan Life Insurance Company (MetLife) established the Office of FEGLI (OFEGLI), an administrative unit to carry out its responsibilities under this agreement, which includes:

- Processing and paying claims;
- Determining whether an insured individual is eligible for a living benefit;
- Determining whether accidental death and dismemberment benefits are payable;
- Determining an employee's eligibility to cancel a waiver of insurance based on satisfactory medical information; and,
- Processing requests for conversions.

The main objective of the audit was to determine if the costs charged and services provided to FEGLI and its subscribers were in accordance with the terms of the contract and applicable Federal regulations.

Our audit identified one finding where MetLife inadvertently retained \$72,000 in excess of the indirect administrative expense cap due to a manual mathematical error in its calculation.



American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts Holding Company for Contract Years 2012 through 2014

SAINT LOUIS, MISSOURI

Report No. 1H-04-00-15-053

SEPTEMBER 28, 2016

American Postal Workers Union Health Plan (APWU) participates in the FEHBP and contracted with a Pharmacy Benefit Manager (PBM) to provide pharmacy benefits and services to its members for contract years 2012 through 2014. PBMs are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM contracts directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, the PBM offers the option of utilizing mail order pharmacies. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. Pharmacy Benefit Managers are used to develop, allocate, and control costs related to the pharmacy claims program.

APWU originally contracted with Medco Health Solutions for PBM services for contract years 2012 through 2014. On April 2, 2012, Medco Health Solutions and Express Scripts, Inc. merged and became wholly-owned subsidiaries of the Express Scripts Holding Company (ESHC). On the date of the merger, ESHC, located in St. Louis, Missouri, assumed the pharmacy operations and responsibilities under the agreement with APWU.

Section 1.26(a) of the contract outlines transparency standards that require PBMs to provide pass-through pricing based on its cost. Our responsibility is to review the performance of ESHC to determine if APWU charged costs to the FEHBP and provided services to its members in accordance with the OPM contract, the agreement between APWU and ESHC, and the Federal regulations.

Our audit consisted of a review of administrative fees, claim payments, fraud and abuse, Health Insurance Portability and Accountability Act compliance, performance guarantees, and rebates related to the FEHBP for contract years 2012 through 2014.

We determined that APWU and/or ESHC needs to strengthen its procedures and controls related to the billing of administrative fees, pharmacy claim payments, and performance guarantee reporting and payment of penalties. Our audit identified the following seven areas requiring improvement:

1. ESHC was unable to accurately support all of the line items it charged for administrative products and services;
2. ESHC failed to properly update pharmacy contract pricing information into its claims system, causing \$9,954 in erroneous claim payments;
3. APWU paid \$16,847 in pharmacy claims on ineligible overage dependent children;
4. APWU did not require ESHC to use OPM's debarred providers list, which resulted in claims paid to debarred providers;
5. APWU paid 96 pharmacy claims incorrectly because override codes were not properly applied by it or the PBM;
6. APWU did not report all of the suspected pharmacy fraud and abuse cases to OPM; and,
7. ESHC failed to submit its 2014 performance report and a \$120,000 penalty to ESHC in a timely manner.



ENFORCEMENT ACTIVITIES

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with over \$1 trillion 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 nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$133 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 and contractor misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our office opened 28 criminal investigations and closed 26, with 162 still in progress. Our criminal investigations led to 18 arrests, 28 indictments and informations, 14 convictions and \$5,274,843 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 \$20,770,779 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 statistical summary of our office's investigative activity, refer to the table on page 33.

HEALTH CARE FRAUD CASES

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 and civil 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 cases that involve harm to the patients, pharmaceutical fraud, and the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

We remain very concerned about the FEHBP's exclusion from the Anti-Kickback Act and have proposed legislation to correct that omission. In our experience, the FEHBP is frequently victimized by the payment of kickbacks.

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 debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions. The following investigative cases represent some of our activity during the reporting period.

HEALTH CARE FRAUD CASES

Pharmaceutical Company Agrees to Pay \$67 Million to Resolve Allegations of Misleading Drug Marketing

In June 2016, Genentech, Inc. and OSI Pharmaceuticals, LLC agreed to pay \$67 million to resolve False Claims Act allegations. As part of the civil settlement, the FEHBP was awarded \$2,377,661 in a lump sum. We were notified of this case after a qui tam lawsuit was filed in 2011 in the United States District Court for the Northern District of California, by a citizen alleging that Genentech and OSI Pharmaceuticals had defrauded the U.S. Government.

A qui tam lawsuit may be filed on behalf of the Federal government if an individual has knowledge of a contractor filing false claims. The government may intercede or allow the plaintiff or relator to prosecute the lawsuit on its behalf. If the qui tam lawsuit is

successful the relator receives a reward of 15-25 percent of the recovery if the government interceded; or 25-30 percent if the government did not intercede.

Genentech, located in South San Francisco, California, and OSI Pharmaceuticals, located in Farmingdale, New York, co-promote the prescription drug Tarceva. Tarceva was approved by the Food and Drug Administration (FDA) as a first line treatment for patients with non-small cell lung cancer or pancreatic cancer who possessed a particular genetic mutation. The settlement resolves allegations that, between January 2006 and December 2011, Genentech and OSI Pharmaceuticals made misleading representations to physicians and other health care providers about the effectiveness of Tarceva to treat certain patients who were poor candidates for Tarceva. Allegations were misleading because there was little evidence to show that Tarceva was effective to treat those patients unless they had never smoked or had a mutation in their epidermal growth factor receptor, which is a protein involved in the growth and spread of cancer cells.

Convicted Maryland Physician Ordered to Pay Over \$3 Million Restitution

In April 2016, a Maryland physician was sentenced to 111 months in prison, followed by three years of supervised release, subsequent to his conviction after an eight day trial. The jury found the physician guilty of two counts of making a false statement related to a health care program, one count of obstruction of justice, four counts of wire fraud, and one count of aggravated identity theft related to a health care fraud scheme. The physician was also ordered to forfeit and pay restitution of \$3,103,875, of which \$862,168 will be returned to the FEHBP.

The physician specialized in interventional pain management. He and his wife, who was also a physician, owned and operated a pain management clinic in Greenbelt, Maryland. The wife was also convicted, but charges against her were dismissed because she died prior to sentencing.



From at least January 2011 through May 2014, the husband and wife defrauded Federal health benefit programs including Medicare, Medicaid, TRICARE, the FEHBP and the Office of Workers' Compensation Programs. They filed insurance claims for procedures that were not performed at all, and also billed for procedures with higher reimbursement amounts than the procedures actually performed. For example, they submitted insurance claims for nerve block injections performed with the use of an imaging guidance machine, but neither owned nor used such a machine. They also falsely documented patient medical files to indicate that an imaging guidance machine had been used to verify needle placement, and caused the alteration or destruction of patient files to conceal the fraud scheme from auditors and law enforcement.

We worked this case jointly with the: Federal Bureau of Investigation (FBI) Defense Criminal Investigations Service (DCIS), U.S. Department of Health and Human Services (HHS) OIG, U.S. Department of Labor (DOL) OIG, and U.S. Postal Service (USPS) OIG.

Psychologist Guilty of Health Care Fraud

Our office conducted an investigation of a licensed and practicing clinical psychologist in New Mexico, who caused claims to be submitted to Federal health care benefit programs, including the FEHBP, for counseling services that were never performed. The psychologist did not actually provide any counseling services for many patients after the initial counseling sessions, yet billed Medicare or the other health care benefit programs for fictitious visits by her patients even after a certain number of her patients stopped coming to her for counseling services.

In May 2016, the psychologist pled guilty to health care fraud and was sentenced to 60 months' probation, a special assessment of \$100, and ordered to pay restitution in the amount of \$157,840. The FEHBP portion of the restitution was \$27,702. The psychologist was also referred for debarment from the FEHBP.

This was a joint case with the FBI and the OPM OIG.

Spouse of Federal Employee Guilty of Identity Theft

A Virginia man pleaded guilty to two counts of identity theft and possession of controlled substances by misrepresentation. In July 2016, he was sentenced to 2 months incarceration, 48 months' probation, and ordered to pay \$2,338 in restitution, of which \$1,885 will be returned to the FEHBP. Our investigation revealed that this man, the spouse of a Federal employee, fraudulently procured controlled substances from numerous retail pharmacies in the Eastern District of Virginia and elsewhere, including Maryland, West Virginia, and California, by assuming the identity of a doctor in Frederick, Maryland. Using the doctor's identity, the spouse submitted false prescriptions to pharmacies, which then caused fraudulent insurance claims to be submitted to the FEHBP and Tricare. The defendant also often used the identities of his wife, his children, and his wife's ex-husband to obtain false prescriptions.

This was a joint investigation between our office and the DCIS.

Drayer Agrees to a \$7 Million Settlement for False Medical Claims

Immediately prior to executing a July 2016 civil settlement agreement with Drayer Physical Therapy Institute, LLC (Drayer), the U.S. Attorney's Office for the District of South Carolina contacted our office and requested OPM's approval to settle FEHBP claims identified by the U.S. Postal Service OIG. Drayer has locations in South Carolina and 14 other states from Pennsylvania to Oklahoma, and this case originated with a qui tam lawsuit filed by former employees of Drayer.

Drayer agreed to pay \$7,000,000 to settle allegations that they violated the False Claims Act by submitting claims to Medicare, TRICARE, and the FEHBP for services provided to multiple patients simultaneously, as though the services were provided to one patient at a time. After determining the FEHBP's full exposure to the alleged fraud, we advised the U.S. Attorney's Office that the FEHBP's damages had been significantly underestimated. The FEHBP's share of



the settlement was subsequently revised to accurately reflect the FEHBP's damages, and the FEHBP will receive \$189,135 from the settlement. The claims resolved by the settlement are allegations only and there was no determination of liability.

Civil Settlement with Medical Device Manufacturer Resolves False Claims Act Allegations

In May 2016, Maryland medical device manufacturer Paradigm Spine agreed to pay the United States \$585,000 to resolve allegations under the False Claims Act. The FEHBP will receive \$38,451 of the civil settlement. Paradigm Spine manufactures and markets the coflex-F device, which is an implant approved by the U.S. Food and Drug Administration for certain spine surgeries. It was alleged that from 2011 to 2013, Paradigm Spine marketed coflex-F for surgical uses that were not approved by the FDA and falsely represented to health care providers that coflex-F was approved for use at multiple spinal levels. Further, from 2012 to 2015, Paradigm Spine allegedly provided health care providers with improper guidance on how to claim reimbursement for coflex-F. As a result of this conduct, the United States claimed that Paradigm Spine caused physicians and hospitals to submit false claims to Federal health care programs for certain spine surgeries that were not eligible for reimbursement. Paradigm denies the allegations.

We investigated this case jointly with the HHS OIG, DCIS, and the FDA.

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.

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. 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.

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

RETIREMENT FRAUD CASES

Son Steals Deceased Mother's Social Security and OPM Annuity Benefits

Pursuant to a recommendation from our office, OPM's Retirement Services periodically conducts a Returned 1099-R Project. The 1099-R is a tax document issued to annuitants and survivor annuitants receiving a retirement annuity benefit. Annuitants cannot properly complete their tax returns without the 1099-R, so it is an important document. Each year, thousands of these forms are returned to OPM by the U.S. Postal Service as undeliverable. The purpose of OPM's Returned 1099-R Projects is to attempt to identify improper payments through an analysis of the undeliverable tax forms. In 2013, OPM suspended payment to over 1,000 annuitants and survivor annuitants as a result of their review of undeliverable 1099-R forms from the 2009 tax year. However, Retirement Services lacked sufficient resources to perform the additional research required to establish with certainty whether those annuitants had passed away. Without establishing a date of death, no overpayment is calculated and recovery of the overpayment is not initiated. The OIG has been and remains concerned that Retirement Services does not have the resources – staff, training, and tools – to perform the tasks necessary to adequately prevent improper payments, or to identify improper payments when they occur. Retirement Services recently finalized an agreement with OPM's Federal Investigative Services to search for death certificates needed to identify annuitant dates of death.

In 2015, the Social Security Administration (SSA) OIG contacted our office regarding a woman in Massachusetts who had been issued post-death Social Security payments and had also received OPM survivor annuity payments. The ensuing joint investigation determined that the survivor annuitant died in 1991 and her son continued to receive her benefit payments for over 22 years. Upon researching her OPM survivor annuity, we discovered that she was one of the many individuals whose payments were suspended by OPM in 2013 as a result of OPM's Returned 1099-R Project, for whom OPM had not established a date of death.

The survivor annuitant and her son had a joint bank account, where the OPM annuity and Social Security benefit payments were electronically deposited. Neither OPM nor Social Security were notified of her death, and both continued to issue payments via electronic funds transfer to the joint bank account. The annuitant's son fraudulently received his deceased mother's Social Security benefits in the amount of \$227,476, and OPM annuity payments totaling \$216,811.

Special Agents from our office and the SSA OIG interviewed the annuitant's son, who admitted that he converted the Social Security benefits and the OPM retirement survivor annuity payments to his own personal use after his mother's death. He pled guilty to theft in the U.S. District Court of Massachusetts. In August 2016, the annuitant's son was sentenced to 5 months home confinement followed by 60 months' probation. Additionally, he was ordered to pay \$444,287 in restitution, with \$216,811 of that sum returned to OPM and the remainder to the SSA. He was also charged a \$4,000 criminal fine and special assessment of \$200.

Remarried Survivor Annuitant Guilty of Fraud

The widow of a Federal retiree pled guilty to theft from the Civil Service Retirement System. In May 2016, she was sentenced in the District of Minnesota to 24 months of probation, 100 hours of community service and ordered to pay OPM restitution in the amount of \$132,527. We learned about this case through an

anonymous online complaint. The widow was eligible for and received survivor annuity payments after the 1995 death of her husband. However, she remarried in 2000, before she reached the age of 55, and therefore lost her entitlement to the survivor annuity payments.

She failed to report her marriage to OPM, and collected survivor annuity payments she was not entitled to for seven years. She divorced in 2007, and thereby regained her eligibility for the survivor annuity for a period of about six months, until she married again later that same year. She failed to report that marriage also, and continued to collect survivor annuity payments she was not entitled to for another seven years. In 2013 and again in 2014, the widow sent OPM written statements claiming she had never remarried. When we interviewed her, she admitted that she sent the false statements to OPM in order to maintain her survivor annuity benefit.

Son Convicted of Theft for Failing to Report his Mother's Death

We initiated this investigation after receiving an allegation that a Federal survivor annuitant died in 2001 and her son continued to receive her survivor annuity benefit payments for over 13 years.

Our investigation confirmed that the annuitant's son maintained a joint bank account with the annuitant where the annuity benefit payments were electronically deposited. The annuitant died in July 2001 and OPM was not notified of her death. OPM continued to issue annuity payments via electronic funds transfer to the bank account jointly held by the annuitant and her son, resulting in an overpayment of \$176,704. Additionally, the annuitant's son also continued to fraudulently receive his mother's Social Security benefits in the amount of \$58,267.

The annuitant's son was interviewed by Special Agents from our office and from the SSA OIG. He stated that he knew the money was not intended for him, but that he withdrew the money monthly from the joint account he shared with his mother and spent it on various living expenses including rent and credit card expenses. He never paid taxes on the money or reported the money as income.

The annuitant's son was indicted for theft of public money in the Western District of Tennessee. In January 2016, he was arrested. In July 2016, he pled guilty and was sentenced to time served, 12 months home detention, and 3 years of supervised release. Additionally, he was ordered to pay restitution of \$176,704 to OPM and \$58,267 to the SSA.

REVOLVING FUND PROGRAM INVESTIGATIONS

Our office investigates allegations of fraud within OPM's Revolving Fund programs, such as the background investigations program and human resources products and services.

Prior to the establishment of the National Background Investigations Bureau (NBIB) effective October 1, 2016, OPM's Federal Investigative Services conducted background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducted 95 percent of all personnel background investigations for the Federal Government. With a staff of over 8,800 Federal and contract employees, FIS processed over 2.6 million background investigations in FY 2016. 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 contract violations, as well as 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 will continue to provide this necessary investigative oversight for the NBIB. We consider such cases to be a serious national security and public trust 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 Revolving Fund investigation represents some of our activities during the reporting period.

Former OPM Contract Background Investigator Convicted of Falsifying Numerous Background Investigations

In October 2011, our office received an allegation from the FIS Integrity Assurance regarding misconduct and false statements made by a former OPM contract background investigator employed by KeyPoint Government Solutions (KeyPoint).

From October 2010 to July 2011, in approximately 50 Reports of Investigations, the background investigator indicated that he had interviewed a source or reviewed a record regarding the subject of the background investigation, when in fact, he had not conducted the interview or obtained the records of interest. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

The former KeyPoint contract background investigator pled guilty, in the U.S. District Court for the District of Columbia, to making a false statement and was sentenced in May 2016 to serve two months incarceration, followed by four months of home detention, 36 months of supervised probation and was ordered to pay restitution of \$85,780 to OPM.

ADMINISTRATIVE INVESTIGATIONS

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations of fraud, waste, abuse or mismanagement at OPM. The following administrative investigations represents some of our activities during the reporting period.

Recommendations Issued After Investigation Found Violations of Federal Acquisition Regulations

On April 29, 2016 the OIG sent OPM's Acting Director a Management Advisory Report containing recommendations for program improvement that arose from our investigation of alleged procurement violations related to USAJOBS. Our investigation found violations of the Federal Acquisition Regulations and OPM contracting policy, including an unauthorized commitment, a Task Order initiated prior to pricing, and efforts by a former OPM manager to limit competition without documented justification for a limited or sole source procurement.

We found no evidence of misconduct on the part of the contractor. The OIG's recommendations to OPM were to:

- Ensure good communication between the contracting office and the program office when determining fair opportunity for potential contractors to compete;
- Require training for program officials and program managers who have input or involvement in the selection of contractors or contract vehicles, or who may be able to influence competition. In addition, supplement basic Contracting Officer Technical Representative courses with basic procurement courses covering a variety of procurement topics; and,
- Bring the OIG's findings on this matter to the attention of OPM's Advocate(s) for Competition.

OPM management concurred with these recommendations and noted that they have already taken some corrective actions and have planned for additional corrective actions.

OPM Employee Misused Government Purchase Card

The OPM OIG received a complaint alleging misuse of a Government Purchase Card. Our investigation determined that six iPads were purchased from a retail store on a day that the authorized cardholder was not scheduled to work. We discovered that a GS-14 employee had forged the signature of the authorized cardholder. The purchase occurred under the pressure of an imminent deadline to use funds obligated for FY 2014, and subsequent to an email from a GS-15 addressed to both the authorized cardholder and the GS-14 containing instructions on what to purchase for the office. However, the purchase card holder was not at work that day. The GS-14 admitted that she took the Government Purchase Card from the desk drawer of the authorized cardholder, drove to a retail store to make the purchase, and signed the cardholder's name on the credit card receipt. The OIG was able to locate all six iPads purchased. This matter was declined for criminal prosecution, and referred to OPM for administrative action. The GS-14 employee received a written reprimand.

OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number and mailing address are listed on our OIG Web site at 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 investigation. 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 1,119 hotline inquiries during the reporting period, with 234 pertaining to health care and insurance issues, 339 concerning retirement, 47 related to Revolving Fund programs, and the remainder fell into other categories. The table on page 33 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 290 preliminary inquiry complaints. Of those preliminary inquiry complaints, 212 related to health care fraud, 46 involved retirement fraud, 20 pertained to OPM's Revolving Fund programs, and the remainder fell into other categories. 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.

Debarment Initiative Update

Effective March 2013, OPM implemented a suspension and debarment program, which is separate from OIG's administrative sanctions of FEHBP health care providers. The program covers the debarment of OPM contractors and employees who have violated the terms of their contract or employment. During this reporting period, the OIG

referred 10 cases to the agency for administrative sanctions, for a total of 101 referrals since the inception of the program. OPM issued debarment letters to 16 individuals between April 1, 2016 and September 30, 2016. The majority of cases we have referred for debarment action were former FIS employees and contractors. Most of these former FIS employees and contractors are referred to us through FIS' Integrity Assurance Group. Although these individuals were removed from Government employment or from the relevant OPM contract, we feel that Government-wide contract debarment action for these individuals is necessary to protect the integrity of Federal programs.

Our office will continue to develop and refer cases where we believe a Government-wide debarment is necessary in order to protect the integrity of OPM, as well as other Federal agencies and programs.

During this reporting period, the Office of Investigations also referred 35 cases involving health care providers to the OIG's Administrative Sanctions Group for potential suspension or debarment from the FEHBP.

Correction of Prior Period Semiannual Report

In our semiannual report for the period ending September 30, 2015, we underreported the total recovery amount in Appendix IX by \$26,453,458 and the OPM Recovery amount by \$173,750. In our semiannual report for the period ending March 31, 2016, we underreported the total recovery amount in Appendix X by \$6,916,795 and the OPM recovery amount by \$41,242. This underreporting occurred because the recovery amounts for several cases were not available until after the prior semiannual reports were 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 34,352 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 547 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 2,448 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.*

Michigan Physician Debarred After Conviction for Medicare Care Fraud

In January 2016, we debarred a Michigan physician specializing in family medicine and his home visiting practice based on his conviction for offences involving Medicare fraud. The physician was a leader of a criminal conspiracy ring that submitted fraudulent claims to Medicare for services that were not provided or that were not performed by a licensed physician.

According to the U. S. Attorney's Office, the physician, through his practice and in concert with family members, and co-workers, billed Medicare more than \$11.5 million for in-home health care services. Court documents report that over \$4 million in claims were submitted under his provider number; and another \$2.4 million under his brother and co-defendant's provider number.

In May 2015, the physician pled guilty in the U.S. District Court, Eastern District, Michigan to a laundry list of charges including:

- Billing Medicare for \$4.2 million in fraudulent claims for in-home health services from August 2008 through September 2012;
- Submitting claims for 350 home visits under provider numbers for himself and his brother while they were out of the country;

- Submitting claims for home visits of patients that were hospitalized at inpatient medical facilities or nursing facilities, as well as submitting claims for services provided to patients who were deceased;
- Employing unlicensed individuals to provide physician home visits and to prepare medical documentation that the physician and other licensed physicians signed as if they had performed the visits when, in fact, no licensed physicians had treated the beneficiaries;
- Pre-signing prescriptions for unlicensed individuals to issue for controlled substances; and,
- Submitting the fraudulent claims through a medical billing service that was owned and operated by his sister.

In November 2015, the physician was sentenced to six years in prison, two years' supervised release, and ordered to pay \$2.1 million in restitution.

The conviction forms a mandatory basis for debarment under the FEHBP's administrative sanctions authority. In determining the appropriate length of debarment, we account for the presence of any aggravating or mitigating factors identified in our administrative regulations. We identified several aggravating factors in the physicians' case warrants a debarment period that exceeds our mandatory three-year term.

We debarred the provider for eight years based on aggravating factors associated with his offences which include the prolonged period in which the fraudulent claim activities were carried out; risk to patient safety through the subterfuge of using unlicensed individuals to treat and prescribe controlled substances to patients; the physician's association with the FEHBP; and the financial loss to a FEHBP carrier. In addition, based upon ownership and control, we debarred his home visiting practice which was used in committing the fraudulent activities.

Illinois Physician Debarred After Medical License Revoked for Sexual Misconduct and Drug Trafficking

Based on a referral from our Office of Investigations, we debarred an Illinois internist in June 2016 after his medical license was revoked by the State of Illinois Department of Financial and Professional Regulation Division of Professional Regulation (Department). The Department's revocation was based on the physician's indictment in the Circuit Court of the Sixteenth Judicial Circuit Kane County, Illinois Criminal Division on charges of aggravated criminal assault; criminal sexual assault; and unlawful possession of cannabis with intent to deliver.

In April 2014, the Department initiated an investigation on the physician, after receiving information that he had engaged in sexually inappropriate conduct with several of his patients. After interviewing the doctor and three of his patients the investigators concluded that in the best interest of the public, his license should be suspended. In June 2014, the Department ordered an immediate temporary suspension of the physician's medical, surgical, and controlled substance licenses pending a formal hearing by its Medical Disciplinary Board (Board).

August 2014, the physician was indicted in the Circuit Court for the Sixteenth Judicial Circuit Kane County, Illinois Criminal Division on one count each of aggravated criminal sexual assault, a Class X felony, and criminal sexual assault, a Class 1 felony, for sexually assaulting a patient in 2012.

In May 2015, while awaiting charges for sexual misconduct, he was arrested and charged with one count each of unlawful possession of cannabis with intent to deliver; possession of cannabis; and production of cannabis plants. The estimated street value of the marijuana was more than \$600,000. In August 2015, physician was indicted in the Circuit Court for the Sixteenth Judicial Circuit Kane County, Illinois Criminal Division for drug trafficking.

In January 2016 the Board held a formal hearing and ordered the revocation of physician's license to practice medicine based on the results of its investigation and his criminal indictments.



Under OPM'S statutory and regulatory authorities, the agency may debar a health care provider whose professional licensure has been revoked, restricted, or deemed nonrenewable by a state licensing authority, for reasons related to the provider's professional competence, professional performance, or financial integrity.

Due to the seriousness of the allegations against the physician, we debarred the physician for an indefinite period pending reinstatement of his Illinois medical license, or the outcome of his trial.

Michigan Physician Debarred After Loss of License Due to Health Care Fraud

Our office debarred a Michigan physician in August 2016 after the Michigan State Department of Licensing and Regulatory Affairs Bureau of Professional Licensing Board of Medicine Disciplinary Subcommittee (Medical Board) revoked the physician's medical license based on his criminal conviction involving health care fraud.

The physician, an internal medicine specialist and the owner of a family medical clinic, was indicted in March 2015 by the State of Michigan, 54B District Court of Ingham County, Lansing, Michigan. An investigation

by the Attorney General's Health Care Fraud Division Office was initiated based on a referral from a State agency. The investigation found that the physician along with three others, were engaged in a scheme that billed Medicaid and private insurance companies for services that should have been performed by a physician, but were done by unlicensed individuals posing as medical professionals. The physician allowed these individuals to evaluate and diagnose patients; make treatment decisions; and write prescriptions. As a result of the investigation, the physician was charged with four counts of Medicaid fraud and two counts of filing false health care claims.

In August 2015, due to the nature of the alleged facts surrounding the criminal investigations and indictment, the Medical Board immediately suspended the physician's medical license to protect the health and safety of the public. In November, 2015 the Medical Board revoked the physician's medical license for violating sections of the Public Health Codes, and Michigan statutes. The physician chose not to contest the Medical Board's decision. According to the Board's Order, the physician may not file a petition for the reinstatement of his medical license until three years after the date of his revocation.

Our debarment of the physician is for an indefinite period pending resolution of his Michigan medical licensure.

EVALUATIONS AND INSPECTIONS ACTIVITIES

The Office of Evaluations and Inspections (OEI) provides an alternative method for conducting independent, credible, and thorough reviews of OPM's programs and operations to prevent waste, fraud, and abuse. OEI quickly analyzes OPM concerns or issues that need immediate attention by using a variety of review methods and evaluation techniques. OEI reports provide OPM management with findings and recommendations that will assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

OPM's Retirement Service's Customer Service Function

WASHINGTON, D.C.

Report Number 4K-RS-00-16-023

SEPTEMBER 28, 2016

OPM's Retirement Service's (RS) is directly responsible for the oversight of the Federal Government's two major retirement systems, the Civil Service Retirement System and the Federal Employees Retirement System. RS provides customer service to approximately 2.6 million annuitants, survivors, and family members by determining Federal employees' eligibility for retirement benefits; issuing annuity

payments to retirees and surviving spouses who are eligible; and collecting premiums for health and life insurance.

RS provides access to its customer service functions through multiple avenues, however the toll-free number listed on OPM's website is annuitants' primary choice for access. RS received approximately 3.5 million calls in total for FYs 2014 and 2015. RS also offers annuitants at its OPM's Headquarters in Washington, DC, a customer Walk-in Center. Additionally, RS actively encourages annuitants to utilize its *Services Online*, a web platform that provides several retirement services transactions on demand.

We conducted this evaluation to address concerns raised by the then Acting Inspector General about the customer service RS is providing to annuitants. Our objective for this evaluation was to assess the customer service RS is providing to annuitants in the following two areas: 1) Annuitants' access to RS's customer service representatives and 2) RS's response time to inquiries received from annuitants.

Our evaluation determined that annuitants using the toll-free number are encountering busy signals and long wait times when attempting to contact RS customer service. Specifically, we found:

- RS did not meet its goal to handle 75 percent of annuitants calls in FY 2015;
- Annuitants who were able to get through on the toll-free number experienced wait times of up to 20 minutes or more before being assisted; and,
- RS's staffing levels do not provide its 2.6 million annuitants adequate access via the toll-free number with a current annuitant to customer service representative ratio of approximately 19,000:1.

Additionally, the *RS Customer Satisfaction Survey*, which measures annuitant and survivor annuitant satisfaction, results for FY 2015 showed:

- Twenty-two percent of respondents stated that the telephone rang without an answer or stayed busy;
- Twenty-five percent of respondents stated they were left on hold for long periods of time; and,
- Seventy-nine percent of written complaints expressed dissatisfaction with the toll-free number, indicating poor telephone service and long wait times.

We also found that RS is not providing timely responses to annuitant's inquiries. Specifically, we found:

- RS is not meeting its goal to respond to all written correspondence within 60 days;
- RS's legal administrative specialists, who also provide annuitants customer service, are not responsive to messages left in their voice mailboxes; and,
- Annuitants are having to make multiple attempts to contact RS for a response to their inquiries.

RS's untimely responses have also affected its *Customer Satisfaction Survey*. The survey results for FY 2015 reported that:

- Sixty-six percent of respondents stated they were satisfied with the amount of time it took RS to respond to written correspondence; which was a 5 percent decrease from FY 2014;
- Twenty-one percent of respondents were dissatisfied with RS's timeliness of resolving problems and complaints; and
- Twenty-one percent of written complaints from the survey indicated dissatisfaction with RS's responses to inquiries, noting multiple attempts to contact RS regarding the same inquiry, and untimely responses to inquiries.

It is important to note the relationship between excessive busy signals and long wait times, and RS's untimely responses to annuitants' inquiries. Annuitants who are not receiving timely responses are making multiple attempts to contact RS, which is potentially a contributing factor to the high number of calls received by RS.

Annuitants Experience Difficulties Gaining Access and Receiving Timely Responses from RS Customer Service

We recommended that RS:

- Establish written policies and procedures for legal administrative specialists to handle annuitants' phone inquiries including guidelines that ensure legal administrative specialists are retrieving voice messages regularly to avoid full voicemail boxes and returning calls within a specified time frame;
- Allocate additional resources to address the backlog of written correspondences; and,
- Develop a plan of action to reduce the specialists to customer ratio to increase the access to RS customer service via the toll-free number.



STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Judicial Actions:

| | |
|--|----|
| Indictments and Informations | 28 |
| Arrests | 18 |
| Convictions | 14 |

Judicial Recoveries:

| | |
|--|---------------------------|
| Restitutions and Settlements | \$5,274,843 |
| Fines, Penalties, Assessments, and Forfeitures | \$20,770,779 ³ |

Hotline Activity:

HEALTH CARE

Referred to:

| | |
|---|-----|
| OPM Program Offices | 103 |
| FEHBP Insurance Carriers or Providers | 50 |
| Other Federal or State Agencies | 11 |
| Informational Only | 61 |
| Inquiries Initiated | 2 |
| Retained for Further Inquiry | 7 |
| Total Received: | 234 |
| Total Closed: | 227 |

PRELIMINARY INQUIRY COMPLAINTS

| | |
|---------------------------|-------|
| Total Received: | 212 |
| Total Closed: | 1,120 |

(continued on next page)

³This 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.



RETIREMENT

Referred to:

| | |
|---|-----|
| OPM Program Offices | 223 |
| Other Federal or State Agencies | 3 |
| Informational Only | 92 |
| Inquiries Initiated | 2 |
| Retained for Further Inquiry | 19 |
| Total Received: | 339 |
| Total Closed: | 320 |

PRELIMINARY INQUIRY COMPLAINTS

| | |
|---------------------------|----|
| Total Received: | 46 |
| Total Closed: | 51 |

REVOLVING FUND

Referred to:

| | |
|---|----|
| OPM Program or Contractor Offices | 34 |
| Other Federal or State Agencies | 5 |
| Informational Only | 7 |
| Inquiries Initiated | 0 |
| Retained for Further Inquiry | 1 |
| Total Received: | 47 |
| Total Closed: | 46 |

PRELIMINARY INQUIRY COMPLAINTS

| | |
|---------------------------|----|
| Total Received: | 20 |
| Total Closed: | 41 |

OTHER

Referred to:

| | |
|---|-----|
| OPM Program or Contractor Offices | 63 |
| Other Federal or State Agencies | 274 |
| Informational Only | 152 |
| Inquiries Initiated | 2 |
| Retained for Further Inquiry | 8 |
| Total Received: | 499 |
| Total Closed: | 491 |

PRELIMINARY INQUIRY COMPLAINTS

| | |
|---------------------------|----|
| Total Received: | 12 |
| Total Closed: | 22 |

HOTLINE CONTACTS AND PRELIMINARY INQUIRY COMPLAINTS:

| | |
|--|-------|
| Total Hotline Contacts and Preliminary Inquiries Received: | 1,409 |
| Total Hotline Contacts and Preliminary Inquiries Closed: | 2,318 |



Health Insurance Carrier Notification Activities:

HEALTH CARE

Declined due to:

| | |
|--|-------|
| Lack of OIG Resources | 459 |
| Low FEHBP Exposure | 353 |
| Allegations Not Substantiated by Carrier | 44 |
| Informational Only | 315 |
| Inquiries Initiated | 14 |
| Retained for Further Inquiry | 788 |
| Total Received: | 1,973 |
| Total Closed: | 1,185 |

Administrative Sanctions Activity:

| | |
|---|--------|
| FIS Cases Referred for Debarment and Suspension | 12 |
| Health Care Debarments and Suspensions Issued | 547 |
| Health Care Provider Debarment and Suspension Inquiries | 2,448 |
| Health Care Debarments and Suspensions in Effect at End of Reporting Period | 34,352 |



APPENDICES

APPENDIX I-A

Final Reports Issued With Questioned Costs for Insurance Programs

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Subject | Number of Reports | Dollar Value |
|--|-------------------|------------------------|
| A. Reports for which no management decision had been made by the beginning of the reporting period | 2 | \$ 915,764 |
| B. Reports issued during the reporting period with findings | 10 | 18,726,283 |
| Subtotals (A+B) | 12 | 19,642,047 |
| C. Reports for which a management decision was made during the reporting period: | 8 | 14,732,355 |
| 1. Disallowed costs | N/A | 15,591,919 |
| 2. Costs not disallowed | N/A | (859,564) ⁴ |
| D. Reports for which no management decision has been made by the end of the reporting period | 4 | 4,909,692 |
| E. Reports for which no management decision has been made within 6 months of issuance | 1 | 537,762 |

⁴Represents the net costs, which includes overpayments and underpayments, to insurance carriers. Underpayments are held (no management decision officially made) until overpayments are recovered.

APPENDIX I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Subject | Number of Reports | Dollar Value |
|--|-------------------|--------------|
| A. Reports for which no management decision had been made by the beginning of the reporting period | 4 | \$ 79,250 |
| B. Reports issued during the reporting period with findings | 1 | 127,229 |
| Subtotals (A+B) | 5 | 206,479 |
| C. Reports for which a management decision was made during the reporting period: | 1 | 42,542 |
| 1. Disallowed costs | N/A | 42,542 |
| 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 | 163,937 |
| E. Reports for which no management decision has been made within 6 months of issuance | 3 | 36,708 |

APPENDIX II

Final Reports Issued With Recommendations for Better Use of Funds

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| 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 | 108,880,417 |
| Subtotals (A+B) | 1 | 108,880,417 |
| 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 | 108,880,417 |
| E. Reports for which no management decision has been made within 6 months of issuance | 0 | 0 |

APPENDIX III

Insurance Audit Reports Issued

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued | Questioned Costs |
|-----------------|--|--------------------|---------------------|
| 1C-2U-00-15-030 | Aetna Open Access of Athens and Atlanta in Blue Bell, Pennsylvania | May 10, 2016 | \$ 766,267 |
| 1C-HA-00-15-033 | Coventry Health Care of Kansas, Inc. in Blue Bell, Pennsylvania | May 10, 2016 | 121,675 |
| 1A-10-09-15-043 | BlueCross BlueShield of Alabama in Birmingham, Alabama | June 8, 2016 | 24,332 |
| 1C-TU-00-16-002 | Humana Coverage First of San Antonio in Louisville, Kentucky | June 8, 2016 | 0 |
| 1C-57-00-16-006 | Kaiser Foundation Health Plan of the Northwest in Portland, Oregon | June 10, 2016 | 0 |
| 1D-80-00-15-044 | Group Health Incorporated in New York, New York | June 13, 2016 | 4,077,394 |
| 1A-99-00-15-047 | Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and Blue Shield Plans in Washington, D.C. | June 17, 2016 | 9,937,273 |
| 1C-JR-00-15-046 | Aetna Open Access of Northern New Jersey in Blue Bell, Pennsylvania | July 15, 2016 | 0 |
| 1J-0A-00-16-033 | Vision Service Plan Vision Care's Federal Employees Dental and Vision Insurance Program Premium Rate Proposal for 2017 in Rancho Cordova, California | July 15, 2016 | 0 |
| 1H-03-00-15-045 | The FEHBP's Pharmacy Operations as Administered by Blue Shield of California Access HMO for Contract Years 2011 through 2013 in San Francisco, California | July 19, 2016 | 12,748 |
| 1J-0C-00-16-034 | FEP Blue Vision's Federal Employees Dental and Vision Insurance Program Premium Rate Proposal for 2017 in Chicago, Illinois, Latham, New York and San Antonio, Texas | July 26, 2016 | 0 |
| 2A-II-00-16-016 | Federal Employees' Group Life Insurance Program as Administered by the Metropolitan Life Insurance Company in Bridgewater, New Jersey and Oriskany, New York | August 10, 2016 | 72,000 |
| 1A-10-11-15-056 | BlueCross BlueShield of Massachusetts in Boston, Massachusetts | August, 15, 2016 | 83,805 |
| 1C-L4-00-16-013 | HMO Health Ohio in Cleveland, Ohio | September 23, 2016 | 3,483,988 |
| 1M-0D-00-16-001 | Multi-State Plan Program Operations at BlueCross BlueShield of Texas in Chicago, Illinois | September 28, 2016 | 0 |
| 1H-04-00-15-053 | American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts Holding Company for Contract Years 2012 through 2014 in St. Louis, Missouri | September 28, 2016 | 146,801 |
| TOTALS | | | \$18,726,283 |



APPENDIX IV

Internal Audit Reports Issued

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|-----------------|---|---------------|
| 4A-CF-00-16-026 | OPM's FY 2015 Improper Payments in Washington, D.C. | May 11, 2016 |
| 4J-OL-00-15-038 | OPM's Administration of the Federal Employees Dental and Vision Insurance Program for FYs 2010 through 2013 in Washington, D.C. | June 3, 2016 |
| 4A-IS-00-15-054 | OPM's Federal Investigative Services' Adjudications Group in Western Pennsylvania and Headquarters in Washington, D.C. | June 17, 2016 |
| 4A-CA-00-15-041 | OPM's Office of Procurement Operations' Contract Management Process in Washington, D.C. | July 8, 2016 |

APPENDIX V

Information Systems Audit Reports Issued

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|-----------------|--|--------------------|
| 4A-CI-00-16-037 | OPM's Infrastructure Improvement Project – Major IT Business Case in Washington, D.C. | May 18, 2016 |
| 1A-10-31-15-058 | Information Systems General and Application Controls at Wellmark, Inc., BlueCross BlueShield in Des Moines, Iowa | June 17, 2016 |
| 6A-0A-00-16-004 | Information Systems General and Application Controls at CACI International, Inc., in Chantilly, Virginia | July 21, 2016 |
| 1C-SG-00-16-007 | Information Systems General and Application Controls at Capital District Physicians' Health Plan in Albany, New York | August 12, 2016 |
| 1A-10-62-16-003 | Information Systems General and Application Controls at Anthem BlueCross BlueShield in Indianapolis, Indiana | August 15, 2016 |
| 1D-89-00-16-011 | Information Systems General and Application Controls at Triple-S Salud, Inc. in San Juan, Puerto Rico | September 28, 2016 |

APPENDIX VI

Evaluation Reports Issued

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|-----------------|--|--------------------|
| 4K-RS-00-16-023 | Evaluation of the OPM's Retirement Services' Customer Service Function at the OPM Headquarters in Washington, D.C. | September 28, 2016 |

APPENDIX VII

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

AS OF SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|-----------------|---|--------------------|
| 4A-CI-00-08-022 | Federal Information Security Management Act for FY 2008 in Washington, D.C.; 19 total recommendations; 2 open recommendations | September 23, 2008 |
| 4A-CF-00-08-025 | OPM's FY 2008 Consolidated Financial Statements in Washington, D.C.; 6 total recommendations; 1 open recommendation | November 14, 2008 |
| 4A-CI-00-09-031 | Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 2 open recommendations | November 5, 2009 |
| 4A-CF-00-09-037 | OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 1 open recommendation | November 13, 2009 |
| 4A-CF-00-10-015 | OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 3 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; 2 open recommendations | November 10, 2010 |
| 1K-RS-00-11-068 | Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 3 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; 3 open recommendations | November 9, 2011 |
| 4A-CF-00-11-050 | OPM's FY 2011 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 1 open recommendation | November 14, 2011 |
| 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; 5 open recommendations | July 16, 2012 |
| 4A-CF-00-11-067 | Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 1 open recommendation | September 13, 2012 |
| 4A-CI-00-12-016 | Federal Information Security Management Act for FY 2012 in Washington, D.C.; 18 total recommendations; 4 open recommendations | November 5, 2012 |
| 4A-CF-00-12-039 | OPM's FY 2012 Consolidated Financial Statements in Washington, D.C.; 3 total recommendations; 1 open recommendation | November 15, 2012 |
| 1K-RS-00-12-031 | OPM's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.; 2 total recommendations; 1 open recommendation | December 12, 2012 |



APPENDIX VII

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

AS OF SEPTEMBER 30, 2016

(Continued)

| Report Number | Subject | Date Issued |
|-----------------|---|-------------------|
| 1H-01-00-12-072 | BlueCross and BlueShield's Retail Pharmacy Member Eligibility in 2006, 2007, and 2011 in Washington, D.C.; 11 total recommendations; 10 open recommendations | November 8, 2013 |
| 4A-CI-00-13-021 | Federal Information Security Management Act for FY 2013 in Washington, D.C.; 16 total recommendations; 5 open recommendations | November 21, 2013 |
| 4A-CF-00-13-034 | OPM's FY 2013 Consolidated Financial Statements in Washington, D.C.; 1 total recommendation; 1 open recommendation | December 13, 2013 |
| 4A-CF-00-14-009 | OPM's FY 2013 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 1 total recommendation; 1 open recommendation | April 10, 2014 |
| 1B-32-00-13-037 | Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia; 41 total recommendations; 1 open recommendation | May 6, 2014 |
| 1A-10-15-13-058 | BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 16 total recommendations; 1 open recommendation | June 6, 2014 |
| 4A-CI-00-14-015 | Information Technology Security Controls of the OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 5 open recommendations | June 6, 2014 |
| 4A-CI-00-14-028 | Status of Cloud Computing Environments within the OPM in Washington, D.C.; 3 total recommendations; 2 open recommendations | July 9, 2014 |
| 4A-RI-00-14-036 | Information Technology Security Controls of OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems FY 2014 in Washington, D.C.; 10 total recommendations; 2 open recommendations | August 19, 2014 |
| 4A-CF-00-14-039 | OPM's FY 2014 Consolidated Financial Statements in Washington, D.C.; 4 total recommendations; 3 open recommendations | November 10, 2014 |
| 4A-CI-00-14-016 | Federal Information Security Management Act for FY 2014 in Washington, D.C.; 29 total recommendations; 16 open recommendations | November 12, 2014 |
| 4A-CI-00-14-064 | Information Technology Security Controls of the OPM's Dashboard Management Reporting System in Washington, D.C.; 4 total recommendations; 3 open recommendations | January 14, 2015 |



APPENDIX VII

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

AS OF SEPTEMBER 30, 2016

(Continued)

| Report Number | Subject | Date Issued |
|-----------------|--|-------------------|
| 3A-CF-00-14-049 | The 2011 and 2012 Long Island Combined Federal Campaigns in Deer Park, New York; 18 total recommendations; 16 open recommendations | February 11, 2015 |
| 3A-CF-00-14-048 | The 2011 and 2012 Northern Lights Combined Federal Campaigns in St. Paul, Minnesota; 29 total recommendations; 2 open recommendations | March 23, 2015 |
| 4K-RS-00-14-076 | The Review of OPM's Compliance with the Freedom of Information Act in Washington, D.C.; 3 total recommendations; 2 open recommendations | March 23, 2015 |
| 1B-43-00-14-029 | Information Systems General and Application Controls and Administrative Expenses at the Panama Canal Area Benefit Plan and its Claims Administrator, AXA Assistance in Panama City, Panama; 12 total recommendations; 5 open recommendations | April 2, 2015 |
| 4A-RS-00-13-033 | Assessing the Internal Controls over OPM's Retirement Services' Retirement Eligibility and Services Office in Washington, D.C.; 7 total recommendations; 3 open recommendations | April 13, 2015 |
| 4A-CF-00-15-025 | OPM's FY 2014 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 4 total recommendations; 2 open recommendations | May 15, 2015 |
| 4A-HR-00-13-055 | The Human Resources Solutions' Pricing Methodologies in Washington, D.C.; 5 total recommendations; 5 open recommendations | June 2, 2015 |
| 4A-CI-00-15-055 | Flash Audit Alert—OPM 's Infrastructure Improvement in Washington, D.C.; 2 total recommendations; 1 open recommendation | June 17, 2015 |
| 1A-99-00-14-069 | BlueCross and BlueShield Association's Fraud Information Management System in Washington, D.C. and Chicago, Illinois; 3 total recommendations; 1 open recommendation | July 14, 2015 |
| 4A-HR-00-15-018 | Information Technology Security Controls of OPM's USA Performance System in Washington, D.C.; 1 total recommendation; 1 open recommendation | July 20, 2015 |
| 1A-99-00-14-046 | Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 2 open recommendations | July 29, 2015 |
| 4A-RI-00-15-019 | Information Technology Security Controls of OPM's Annuitant Health Benefits Open Season System in Washington, D.C.; 7 total recommendations; 6 open recommendations | July 29, 2015 |



APPENDIX VII

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

AS OF SEPTEMBER 30, 2016

(Continued)

| Report Number | Subject | Date Issued |
|-----------------|--|-------------------|
| 4A-HR-00-15-015 | Information Technology Security Controls of OPM's GP Plateau Baseline 6 Learning Management System in Washington, D.C.; 12 total recommendations; 3 open recommendations | July 31, 2015 |
| 1C-QA-00-14-045 | Independent Health Plan in Buffalo, New York; 3 total recommendations; 2 open recommendations | August 12, 2015 |
| 1C-E3-00-15-020 | Information Systems General and Application Controls at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in Silver Spring, Maryland; 8 total recommendations; 2 open recommendations | August 28, 2015 |
| 1C-22-00-14-071 | Aetna Health Fund in Blue Bell, Pennsylvania; 2 total recommendations; 2 open recommendations | August 31, 2015 |
| 1C-51-00-14-066 | Health Insurance Plan of Greater New York in New York, New York; 3 total recommendations; 2 open recommendations | August 31, 2015 |
| 4A-RI-00-16-014 | Management Alert of Serious Concerns Related to OPM's Procurement Process for Benefit Programs in Washington, D.C.; 4 total recommendations; 4 open recommendations | October 14, 2015 |
| 4A-CI-00-15-011 | Federal Information Security Modernization Act of FY 2015 in Washington, D.C.; 27 total recommendations; 18 open recommendations | November 10, 2015 |
| 4A-CF-00-15-027 | OPM's FY 2015 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 5 open recommendations | November 13, 2015 |
| 1A-10-17-14-037 | Health Care Service Corporation in Abilene, Texas; 16 total recommendations; 4 open recommendations | November 19, 2015 |
| 4K-RS-00-16-024 | The OIG's Special Review of OPM's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group LLC, and its subcontractor, CSIdentity in Washington, D.C.; 2 total recommendations; 2 open recommendations | December 2, 2015 |
| 4A-IS-00-15-034 | Information Systems General and Application Controls at Key Point Government Solutions in Loveland and Thornton, Colorado; 17 total recommendations; 4 open recommendations | December 9, 2015 |
| 1A-99-00-15-008 | Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 8 total recommendations; 8 open recommendations | January 21, 2016 |
| 1C-3A-00-15-012 | Information Systems General and Application Controls at AultCare Health Plan in Canton and Columbus, Ohio; 16 total recommendations; 6 open recommendations | January 21, 2016 |



APPENDIX VII

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

AS OF SEPTEMBER 30, 2016

(Continued)

| Report Number | Subject | Date Issued |
|-----------------|--|-------------------|
| 1C-76-00-15-021 | Information Systems General and Application Controls at Union Health Service, Inc. in Chicago, Illinois; 25 total recommendations; 11 open recommendations | February 16, 2016 |
| 4K-RS-00-15-050 | The Evaluation of OPM's Oversight of the Federal Workers' Compensation Program in Washington, D.C.; 5 total recommendations; 5 open recommendations | March 29, 2016 |
| 1C-WD-00-15-039 | Dean Health Plan in Madison, Wisconsin; 3 total recommendations; 1 open recommendation | March 28, 2016 |



APPENDIX VIII

Most Recent Peer Review Results

AS OF SEPTEMBER 30, 2016

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 <i>(Issued by the Office of the Special Inspector General for Afghanistan Reconstruction)</i> | September 22, 2015 | Pass ⁵ |
| System Review Report on the Amtrak Office of Inspector General Audit Organization <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i> | January 29, 2016 | Pass ⁵ |
| Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Railroad Retirement Board <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i> | August 13, 2014 | Compliant ⁶ |
| Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management <i>(Issued by the Office of Inspector General, U.S. Department of State)</i> | June 21, 2013 | Compliant ⁶ |

⁵A peer review rating 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. The Peer Review does not contain any deficiencies or significant deficiencies.

⁶A rating of **Compliant or Full Compliance** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.



APPENDIX IX Investigative Recoveries

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| OIG Case Number | Case Category | Action | OPM Recovery (Net) | Total Recovery Amount (All Programs/ Victims) | Fines, Penalties, Assessments, and Forfeitures |
|--------------------|---|--------------------|--------------------|---|--|
| I-12-00636 | Federal Investigative Services Fraud | Financial Recovery | 105,432 | 105,432 | 0 |
| I-12-00025 | Federal Investigative Services Fraud | Sentenced | 85,780 | 85,780 | 100 |
| TOTAL | Federal Investigative Services Fraud | | \$ 191,212 | \$ 191,212 | \$ 100 |
| I 2011 00576 | Healthcare Fraud | Civil Action | 2,377,661 | 67,000,000 | 0 |
| I-12-00546 | Healthcare Fraud | Civil Action | 67,532 | 690,441 | 0 |
| I-13-00684 | Healthcare Fraud | Civil Action | 189,135 | 7,000,000 | 0 |
| I-13-01055 | Healthcare Fraud | Civil Action | 12,387 | 165,000 | 0 |
| I-14-01341 | Healthcare Fraud | Civil Action | 38,451 | 585,000 | 0 |
| C-15-00734 | Healthcare Fraud | Civil Action | 139,781 | 25,000,000 | 0 |
| I 2011 00829 | Healthcare Fraud | Sentenced | 0 | 0 | 21,600 |
| I 2011 00829 | Healthcare Fraud | Sentenced | 0 | 197,946 | 20,742,454 |
| I-13-00071 | Healthcare Fraud | Sentenced | 862,168 | 3,103,875 | 900 |
| I-14-00476 | Healthcare Fraud | Sentenced | 27,702 | 157,840 | 100 |
| I-14-01420 | Healthcare Fraud | Sentenced | 0 | 475,924 | 400 |
| I-15-00125 | Healthcare Fraud | Sentenced | 1,885 | 2,338 | 200 |
| I-15-00412 | Healthcare Fraud | Sentenced | 0 | 21,293,201 | 100 |
| TOTAL | Healthcare Fraud | | \$3,716,702 | \$125,671,565 | \$20,765,754 |
| C-15-01013 | Combined Federal Campaign Fraud | Civil Action | 0 | 75,825,653 | 0 |
| TOTAL | Combined Federal Campaign Fraud | | \$0 | \$ 75,825,653 | \$0 |
| C-15-00949 | Retirement Fraud | Financial Recovery | 56,512 | 56,512 | 0 |
| I-14-00458 | Retirement Fraud | Sentenced | 115,441 | 115,441 | 300 |
| I-14-00715 | Retirement Fraud | Sentenced | 0 | 40,000 | 25 |
| I-14-00837 | Retirement Fraud | Sentenced | 132,527 | 132,527 | 100 |
| I-15-00214 | Retirement Fraud | Sentenced | 176,704 | 234,971 | 200 |
| I-15-01060 | Retirement Fraud | Sentenced | 216,811 | 444,28 | 4,200 |
| I-15-02277 | Retirement Fraud | Sentenced | 668,934 | 668,934 | 100 |
| TOTAL | Retirement Fraud | | \$1,366,929 | \$1,692,672 | \$4,925 |
| GRAND TOTAL | | | \$5,274,843 | \$203,381,102 | \$20,770,779 |

Note: Cases that are listed multiple times indicate there were multiple subjects.



APPENDIX X

Summary of Recommendations Issued by Office of Investigations More Than Six Months Old Pending Corrective Action

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|-----------------|--|--------------------|
| N/A | Review of FIS Background Investigations Process in Washington, D.C.; 3 total recommendations; 3 open recommendations | August 15, 2014 |
| 4A-RS-00-15-014 | Results of the OIG's Special Review of OPM's Quality Assessment of USIS's Background Investigations in Washington, D.C.; 1 total recommendation; 1 open recommendation | September 22, 2015 |

APPENDIX XI

Summary of Management Advisory Reports Issued by Office of Investigations

APRIL 1, 2016 TO SEPTEMBER 30, 2016

| Report Number | Subject | Date Issued |
|---------------|---|----------------|
| I-12-00464 | Management Advisory on the Recommendations for Improvement Pursuant to an Investigation of Improper Contracting Practices for the USAJOBS Program in Washington, D.C. | April 29, 2016 |

INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)

| | <i>Page</i> |
|---|-------------|
| Section 4 (a) (2): Review of legislation and regulations | No Activity |
| Section 5 (a) (1): Significant problems, abuses, and deficiencies | 1-32 |
| Section 5 (a) (2): Recommendations regarding significant problems, abuses, and deficiencies. | 1-17 |
| Section 5 (a) (3): Recommendations described in previous semiannual reports on which corrective action has not been completed | No Activity |
| Section 5 (a) (4): Matters referred to prosecutive authorities | 19-29 |
| Section 5 (a) (5): Summary of instances where information was refused during this reporting period. | No Activity |
| Section 5 (a) (6): Listing of audit reports issued during this reporting period | 39-40 |
| Section 5 (a) (7): Summary of particularly significant reports. | 1-32 |
| Section 5 (a) (8): Audit reports containing questioned costs | 37-39 |
| Section 5 (a) (9): Audit reports containing recommendations for better use of funds. | No Activity |
| Section 5 (a) (10): Summary of unresolved audit reports issued prior to the beginning of this reporting period. | 41-45 |
| Section 5 (a) (11): Significant revised management decisions during this reporting period. | No Activity |
| Section 5 (a) (12): Significant management decisions with which the OIG disagreed during this reporting period. | No Activity |
| Section 5 (a) (14) (A): Peer reviews conducted by another OIG | 46 |
| Section 5 (a) (16): Peer reviews conducted by the OPM OIG | 46 |





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