



Semiannual Report to Congress



United States
Office of Personnel Management
OFFICE OF THE INSPECTOR GENERAL

October 1, 2017 – March 31, 2018

OFFICE OF THE INSPECTOR GENERAL



Indicators

Financial Impact:

Audit Recommendations for Recovery of Funds.	\$92,856,953
Management Commitments to Recover Funds.	\$28,409,649
Recoveries through Investigative Actions.	\$7,808,415

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	28
Evaluation Reports Issued	1
Cases Closed	209
Indictments and Informations	37
Criminal Complaints.	1
Arrests	28
Convictions.	20
Hotline Contacts and Complaints Received	1,233
Hotline Contacts and Complaints Closed.....	1,162
Health Care Provider Debarments and Suspensions	577
Health Care Provider Debarment and Suspension Inquiries.	2,296



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Message from the Acting Inspector General

In March 2018, the U.S. Office of Personnel Management (OPM) welcomed Dr. Jeff T.H. Pon and Michael J. Rigas as Director and Deputy Director, respectively. In recognition of their arrival, I would like to reflect upon the important role of agency cooperation with the Office of the Inspector General (OIG), and highlight a recent instance where such cooperation has proven vital to enabling the OIG to carry out its statutory mission to promote economy, efficiency, and effectiveness relating to the administration of OPM's programs and operations.

In the course of conducting the OIG's oversight work, OIG auditors, investigators, and evaluators routinely rely on support from other OPM employees. Whether we are requesting documents, conducting witness interviews, or seeking background information, our work often requires the assistance of those employees who carry out OPM's mission. Employee cooperation helps us detect and prevent fraud, waste, and abuse involving OPM's programs and operations as well as to support OPM's mission to lead and serve the Federal Government in enterprise human resources management.

A recent audit highlights the beneficial role of agency cooperation in OIG oversight. In February 2018, we issued a Flash Audit Alert to OPM because one of the health insurance carriers participating in the Federal Employees Health Benefits Program (FEHBP) refused to cooperate with requests from our information systems auditors. Specifically, Health Net of California, Inc., would not permit our auditors to conduct vulnerability scans and configuration management testing, and also refused to comply with our request for documents. These are routine steps in OIG audits of contractor information systems and are crucial to ensuring that the protected health information (PHI) collected by FEHBP carriers in the course of providing health care benefits is maintained in a secure and confidential manner.

Prior to issuing the Flash Audit Alert, we reached out to the contracting officer overseeing the health insurance carrier's FEHBP contract and requested assistance in addressing the looming obstruction. The contracting officer acknowledged our authority and recognized the vital importance of making

(continued on next page)



Message from the Acting Inspector General

sure that the PHI and personally identifiable information (PII) of FEHBP enrollees are kept safe and secure. The contracting officer and the agency's Acting Chief Information Security Officer supported the OIG's right to conduct these scans and quickly and clearly communicated to Health Net executives the agency's expectation that the carrier cooperate with the audit.

In the end, the carrier acquiesced, agreeing to allow our auditors to perform the scans in the near future and to provide the requested documents. Because of the agency's support and recognition of the importance of OIG oversight to the safety and security of FEHBP enrollees' PHI and PII, our auditors have resumed their IT audit work on this engagement. Although obviously we wish that the health insurance carrier had not objected, we could not be more pleased with how the situation was resolved with the assistance of OPM.

I extend my welcome to Director Pon and Deputy Director Rigas, and I look forward to a productive and positive relationship with them at OPM.

A handwritten signature in black ink that reads "Norbert E. Vint". The signature is fluid and cursive.

Norbert E. Vint

Acting Inspector General

Mission Statement

Our mission is to provide independent and objective oversight of the U.S. Office of Personnel Management's programs and operations.

Vision

Oversight through Innovation.

Core Values

Vigilance

Safeguard OPM's programs and operations from fraud, waste, abuse, and mismanagement.

Integrity

Demonstrate the highest levels of professionalism, independence, and quality in our work and operations.

Empowerment

Emphasize our commitment to invest in our employees and promote our effectiveness.

Excellence

Promote best practices in OPM's management of program operations.

Transparency

Foster clear communication with OPM leadership, Congress, and the public.

Strategic Objectives

Promote efficiency and protect OPM programs, operations, and stakeholders from fraud, waste, and mismanagement.

Advance excellence and innovation.

Provide relevant, accurate, and timely information to stakeholders.

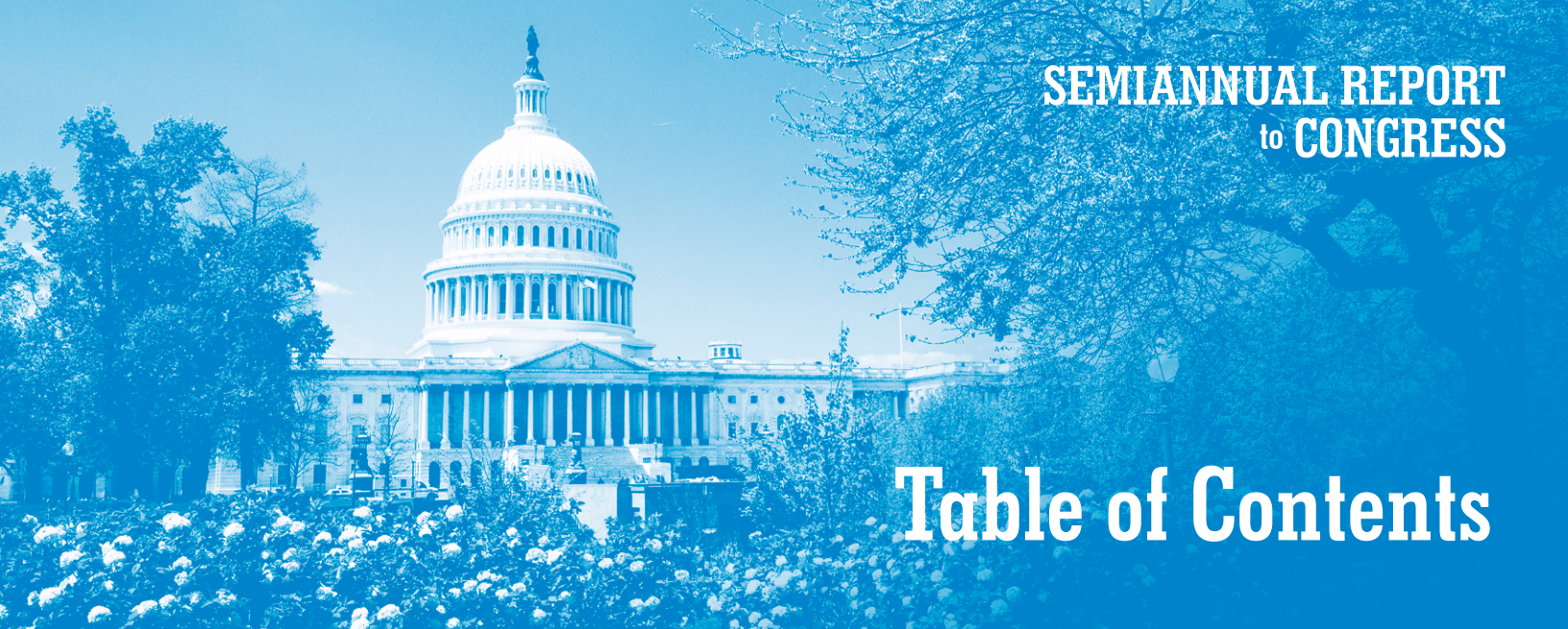


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Field Offices



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. The Office of Audits 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 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 (LOC) account, which is not solely dependent on total premiums paid to the carrier during the year.

During the current reporting period, we issued 14 final audit reports on organizations participating in the FEHBP, which contained recommendations for the return of \$92.6 million 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 required 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.

SSSG 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 (MLR) Audits

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

***Medical Loss Ratio** 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-rated 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-rated 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 pay a subsidization penalty 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 (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 (issuers) to offer 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 Program Development and Support office, formerly the National Healthcare Operations office, has overall responsibility for program administration. In 2017, the MSP Program universe



consisted of approximately 23 state-level issuers covering 22 states. 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.

The report summaries below highlight notable audit findings for the MSP Program issuers and FEHBP carriers audited during this reporting period.

Health Insurance Plan of New York

NEW YORK, NEW YORK

Report No. 1C-51-00-16-057

DECEMBER 13, 2017

Health Insurance Plan of New York (Plan) has participated in the FEHBP since 1960, and provides health benefits to FEHBP members in the Greater New York area. The audit covered contract years 2015 and 2016. During this period, the FEHBP paid the Plan approximately \$172.7 million in premiums.

Our audit identified defective pricing to the FEHBP totaling \$1,579,859 in 2015 and 2016, including \$75,214 for lost investment income.

Specifically, we found that the Plan:

- Applied an incorrect children's and preventive dental loading to the FEHBP's 2015 and 2016 rates;
- Applied an incorrect co-pay value for a dialysis benefit to the FEHBP's 2015 and 2016 rates;
- Erred in its 2015 and 2016 Medicare loading calculations by utilizing incorrect benefit loadings, misstating FEHBP Medicare enrollment, and using unsupported Medicare Advantage rates; and
- Applied an unsupported and inconsistent regional adjustment factor to the FEHBP's 2015 and 2016 rates.

Non-Compliance with the FEHBP Regulations Resulted in Program Overcharges of Nearly \$1.6 Million

The Plan agreed with most of our audit findings and ultimately returned the entire amount questioned to the FEHBP.

BlueCross BlueShield of Alabama

BIRMINGHAM, ALABAMA

Report No. 1M-OG-00-17-034

JANUARY 16, 2018

The BlueCross BlueShield (BCBS) Association, on behalf of participating BCBS plans, entered into a contract with OPM to participate in the MSP

Areas of Non-Compliance with OPM's Contract Result in Potential Delays to Coverage Access and an Overpayment of Premiums for MSP Program Members

Program. Along with its participating licensees, the BCBS Association offers 201 MSP options in 21 states. BlueCross BlueShield of Alabama (BCBSAL) was one of 21 BCBS plans, or State-Level Issuers, participating in the MSP Program in 2017.

BCBSAL is the largest provider of healthcare

benefits in Alabama and administers health, dental, and pharmacy programs that cover over 3 million members. In 2017, BCBSAL offered two MSP options on the Exchange (Marketplace), including both a gold and silver plan.

The audit covered BCBSAL's compliance with the 2017 contract and applicable regulations. Our auditors identified two areas of non-compliance.

Specifically, we found that:

- BCBSAL processed six Healthcare Insurance Casework System cases untimely; and
- BCBSAL processed errors untimely, which resulted in three members overpaying approximately \$982 for their health insurance premiums.

BCBSAL agreed with all of the audit findings and implemented corrective actions to address them.



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. Experience-rated HMOs also 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.

BlueCross BlueShield Service Benefit Plan

The BCBS Association, on behalf of participating BCBS plans, entered into a Government-wide Service Benefit Plan with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBS Association delegates authority to participating local BCBS plans throughout the United States to underwrite and process the health benefit claims of its Federal subscribers. Approximately 64 percent of all FEHBP subscribers are enrolled in BCBS plans.

The BCBS 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 BCBS Association, BCBS plans, and OPM. The BCBS 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 BCBS 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 accounting for all FEP funds.

Summaries of the BCBS final reports issued this period are provided below and on pages 11 – 12 (in the Information Systems Audits section) to highlight our notable audit findings.

Cash Management Activities for a Sample of BlueCross and/or BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-17-001

MARCH 14, 2018

For a sample of 20 BCBS plans (from a universe of 64 BCBS plans), our focused audit covered cash management activities and practices from 2015 through June 30, 2016. Our sample included Premera BlueCross and most of the BCBS plans with FEHBP health benefit payments of \$400 million or less in 2015 (except for BCBS of Rhode Island and several BCBS plans that are part of multi-plan companies, such as Anthem Inc. and Regence).

The objective of this focused audit was to determine whether the 20 BCBS plans in our sample handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP. To accomplish our audit objective, we reviewed the plans' LOC account drawdowns, working capital calculations, adjustments and/or balances, United States Treasury offsets, and interest income transactions from 2015 through June 30, 2016, as well as the plans' dedicated FEP investment account transactions during the audit scope and balances as of June 30, 2016.

**BCBS Plans
Returned \$6.3
Million in
Questioned Amounts
to the FEHBP**

Our auditors identified monetary findings for seven of the BCBS plans, questioning \$6,315,970 in cash management activities and lost investment income. The monetary findings included the following:

- \$3.2 million in excess FEHBP funds held in the plans' dedicated FEP investment accounts;



- \$2.1 million for LOC account overdraws (representing overcharges to the FEHBP) and applicable lost investment income on the overdraws;
- \$900,000 for health benefit refunds that had not been returned to the FEHBP as of June 30, 2016 and related lost investment income;
- \$8,000 for excess FEHBP funds held in the plans' dedicated FEP investment accounts;
- \$7,000 for an unreturned United States Treasury offset and related lost investment income; and
- \$3,000 for unreturned interest income.

The BCBS Association and applicable BCBS plans agreed with our audit findings and these plans returned all of the questioned amounts to the FEHBP.

BlueShield of California

SAN FRANCISCO, CALIFORNIA

Report No. 1A-10-67-17-021

MARCH 29, 2018

Our audit of the FEHBP operations at BlueShield of California (Plan) covered administrative expense charges from 2011 through 2015, as well as miscellaneous health benefit payments and credits and cash management activities from January 2012 through September 2016. We also reviewed the Plan's fraud and abuse program activities and practices from January 2015 through September 2016. For contract years 2011 through 2015, the Plan paid approximately \$2 billion in FEHBP health benefit payments and charged the FEHBP \$283 million in administrative expenses.

We questioned \$8,059,422 in health benefit refunds and recoveries, medical drug rebates, administrative expenses, cash management activities, and lost investment income. The monetary findings included the following:

- \$5.7 million for administrative expense charges that were unallowable, unreasonable, and/or did not benefit the FEHBP and for applicable lost investment income on these charges;

- \$2.1 million in excess FEHBP funds held by the Plan in the dedicated FEP investment account as of September 30, 2016;
- \$242,000 for five health benefit refunds, four medical drug rebate amounts, and one fraud recovery that had not been returned to the FEHBP as of September 30, 2016, as well as lost investment income on FEP funds that were returned untimely to the FEHBP; and
- \$7,000 for FEHBP funds that were inadvertently not maintained by the Plan in the dedicated FEP investment account and \$157 for applicable lost investment income on these funds.

**BlueShield of
California Returned
Questioned Amounts
of \$8 Million to
the FEHBP**

Our auditors also concluded that the Plan complied with the communication and reporting requirements for fraud and abuse cases that are set forth in FEHBP Carrier Letter 2014-29. The BCBS Association and Plan agreed with all of the questioned amounts. As part of our review, we verified that the Plan returned these questioned amounts to the FEHBP.

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 issued one audit report on an employee organization plan during this reporting period, which is highlighted below.



Compass Rose Benefits Group

RESTON, VIRGINIA

Report No. 1B-42-00-17-006

JANUARY 16, 2018

The Compass Rose Benefits Group (Group) is a non-profit insurance provider that offers health insurance plans for eligible civilian employees and retirees. The Group is an experience-rated fee-for-service employee organization plan with a preferred provider organization that offers health care to eligible enrollees and their families. The Group is the underwriter and administrator of the Compass Rose Health Plan.

The objective of our audit was to determine whether the Group handled FEHBP funds in accordance with the FEHBP contract and applicable laws and regulations concerning cash management in the FEHBP. Our audit covered the Group's cash management activities and practices related to FEHBP funds from 2014 through June 30, 2016, for the Compass Rose Health Plan. Due to concerns with the Group's working capital funds, we expanded our scope to also include these funds from July 2016 through December 2016 for the Compass Rose Health Plan.

**Auditors Question
and the Group
Returns Over
\$3.4 Million in
Cash Management
Activities**

In total, we questioned \$3,480,136 in cash management activities. Specifically, we determined that the Group held excess FEHBP funds of \$3,480,136 in the dedicated FEHBP investment account as of December 31, 2016. The Group agreed with this finding and immediately returned these excess funds to the FEHBP.

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.

We issued two experience-rated comprehensive medical plan audit reports during this reporting period, which are highlighted below.

Aetna Health of Utah Inc.

SANDY, UTAH

Report No. 1D-9K-00-17-004

DECEMBER 13, 2017

Prior to 2016, Aetna Health of Utah Inc. (Plan), doing business as Altius Health Plan, was an experience-rated HMO plan that provided health benefits to Federal enrollees and their families. Plan enrollment for this experience-rated HMO plan was open to all Federal employees and annuitants in the Plan's service area, which included Utah and certain counties in Idaho and Wyoming. In 2016, the Plan discontinued as an experience-rated HMO plan and changed to a community-rated HMO plan. After discontinuing the experience-rated HMO plan, the Plan was required to fulfill all of the requirements in the FEHBP contract during what is known as a run-out phase, which usually takes two or more years. For example, the Plan continues to process, pay, and/or adjust health benefit claims for services that were incurred in contract years 2015 and prior; provide customer service; process claim overpayment recoveries and pharmacy drug rebates; and account for FEHBP funds. Since January 1, 2016, the experience-rated HMO plan has been in the run-out phase.

The audit covered the Plan's cash management activities and practices related to FEHBP funds from 2014 through June 30, 2016. Specifically, we reviewed the Plan's LOC account drawdowns, working capital calculations, adjustments and/or balances, interest income transactions, and dedicated FEHBP investment account activity and balances to determine if the Plan handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP. Due to concerns with the Plan's working capital funds, we expanded our scope to also include these funds from July 2016 through March 2017.



Aetna Health of Utah Inc. Returned Questioned Amounts of \$2.4 Million to the FEHBP

Our auditors questioned \$2,420,230 in cash management activities. Specifically, we determined that the Plan held excess FEHBP funds of \$2,419,599 in the dedicated FEHBP investment account as of June 30, 2016. We also determined that the Plan held interest income of \$631 earned on FEHBP funds in the dedicated investment account that had not been returned to the FEHBP. The Plan agreed with all of these questioned amounts. As part of our audit, we verified that the Plan returned these questioned amounts to the FEHBP.

BlueShield of California Access+ HMO

SAN FRANCISCO, CALIFORNIA

Report No. 1D-SI-00-17-022

FEBRUARY 28, 2018

BlueShield of California Access+ HMO (Plan), doing business as BlueShield of California, is an experience-rated HMO that provides health benefits to Federal enrollees and their families. Plan enrollment is open to all Federal employees and annuitants in the Plan's service area, which includes most of Southern California.

Our audit of the FEHBP operations at BlueShield of California Access+ HMO covered health benefit refunds and recoveries, including pharmacy and medical drug rebates, and cash management activities from January 2012 through September 2016, as well as administrative expense charges from 2011 through 2015. We also reviewed the Plan's fraud and abuse program activities and practices from January 2015 through September 2016. For contract years 2011 through 2015, the Plan processed approximately \$547 million in FEHBP health benefit payments and charged the FEHBP \$33 million in administrative expenses.

We questioned \$4,908,939 in health benefit refunds and recoveries, administrative expenses, cash management activities, and lost investment income. Our auditors also identified a procedural finding regarding the Plan's fraud and abuse program. The monetary findings included the following:

- \$2.1 million for pharmacy and medical drug rebates that had not been returned to the FEHBP and \$107,168 for lost investment income on drug rebates returned untimely to the FEHBP;
- \$1.4 million for unreturned vendor credit recoveries (from subrogation and provider audit recovery vendors) and for applicable lost investment income on these recoveries;
- \$1.2 million for administrative expense charges that were unallowable and/or did not benefit the FEHBP for applicable lost investment income on these charges;
- \$200,000 in excess FEHBP funds held by the Plan in the dedicated FEHBP investment account as of September 30, 2016;
- \$22,000 for unreturned United States Treasury offsets and for applicable lost investment income; and
- \$1,000 for investment income earned on funds held in the dedicated FEHBP investment account that had not been returned 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 set forth in the FEHBP contract and Carrier Letter 2014-29. Specifically, the Plan did not report all fraud and abuse cases to the OIG. Without awareness of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

The Plan agreed with all of the questioned amounts as well as the procedural finding regarding the Plan's fraud and abuse program.

Auditors Question \$4.9 Million in Health Benefit Refunds and Recoveries, Administrative Expenses, Cash Management Activities, and Lost Investment Income



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 mature 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.

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Federal Information Security Modernization Act Audit Fiscal Year 2017

WASHINGTON, D.C.

Report No. 4A-CI-00-17-020

OCTOBER 27, 2017

The Federal Information Security Modernization Act of 2014 (FISMA) is designed to ensure that the information systems and data supporting Federal operations are adequately protected. The Act emphasizes that agencies implement security planning as part of the life cycle of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's Inspector General (IG).

We audited OPM's compliance with FISMA requirements as defined in the U.S. Department of Homeland Security Office of Cybersecurity and

Communications Fiscal Year (FY) 2017 IG FISMA Reporting Metrics. The FY 2017 FISMA IG reporting metrics fully adopted a maturity model evaluation system derived from the National Institute of Standards and Technology's Cybersecurity Framework. The Cybersecurity Framework is comprised of seven "domain" areas, and the modes (i.e., the number that appears most often) of the domain scores are used to derive the agency's overall cybersecurity score. In FY 2017, OPM's cybersecurity maturity level is measured as "2 – Defined," which means that policies, procedures, and strategy are formalized and documented, but are not consistently implemented.

Our audit determined that OPM has made improvements in its Security Assessment and Authorization (Authorization) program. We upgraded the previous material weakness related to Authorizations to a significant deficiency for FY 2017 based on OPM's "Authorization Sprint" and the agency's continued efforts to maintain Authorizations for all information systems.

However, we once again identified a significant deficiency in OPM's information security management structure. OPM is not making substantial progress in implementing our FISMA recommendations from prior audits. While resource limitations certainly impact the effectiveness of OPM's cybersecurity program, the staff currently in place is not fulfilling its responsibilities that are outlined in OPM policies and required by FISMA.



The sections below provide a high level outline of OPM's performance in each of the cybersecurity framework functions:

Risk Management

OPM is working to implement a comprehensive inventory management process for its system interconnections, hardware assets, and software. OPM is also working to establish a risk executive function that will help ensure that risk assessments are completed and risk is communicated throughout the organization.

Configuration Management

OPM continues to develop and maintain baseline configurations and approved standard configuration settings for its information systems. The organization is also working to establish routine audit processes to ensure that its systems maintain compliance with established configurations.

Identity, Credential, and Access Management

OPM is continuing to improve upon its program by establishing an agency Identity, Credential, and Access Management strategy, and ensuring that an auditing process is implemented for all contractor access.

Security Training

OPM has implemented an IT security training program, but should perform a workforce assessment to identify any gaps in its IT security training needs.

Information Security Continuous Monitoring

OPM has established many of the policies and procedures surrounding Information Security Continuous Monitoring, but the organization has not completed the implementation and enforcement of the policies. OPM also continues to struggle with conducting a security controls assessment on all of its information systems. This has been an ongoing weakness at OPM for over a decade.

Incident Response

OPM has made the greatest strides this fiscal year in the incident response domain. Based upon our audit work, OPM has successfully implemented all of the FISMA metrics at the level of "consistently

implemented" or higher. As such, we are closing our FY 2016 recommendation related to the incident response program.

Contingency Planning

OPM has not implemented several of the FISMA

**OPM is Not Making
Substantial Progress
Implementing
FISMA Audit
Recommendations**

requirements related to contingency planning, and continues to struggle with maintaining its contingency plans as well as conducting contingency plan tests on a routine basis.

Information Systems General and Application Controls at AvMed Health Plan

MIAMI, FLORIDA

Report No. 1C-ML-00-17-027

DECEMBER 18, 2017

Our information technology (IT) audit focused on the claims processing applications used to adjudicate FEHBP claims for AvMed Health Plan (AvMed) members, as well as the various processes and IT systems used to support these applications.

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

Risk Management

AvMed has an adequate risk assessment methodology in place. However, AvMed could make improvements in this area with more thorough vendor management and risk acceptance policies and procedures.

Access Controls

Physical access controls could be improved to prevent unauthorized access to AvMed's data centers. Furthermore, logical access controls could be improved by implementing multi-factor authentication for privileged and remote system users and implementing segregation of duties controls in the access provisioning process.



Network Security

AvMed could improve its network security posture by restricting access from unauthorized devices and improving network segmentation controls. Network monitoring policies and procedures are in place to detect and investigate security events. Furthermore, AvMed has a thorough incident response program in place.

Configuration Management

AvMed does not conduct full scope vulnerability scanning of its server network and does not have formally documented security configuration standards for its servers. In addition, AvMed does not have policies and procedures to ensure only supported software is used.

Contingency Planning

AvMed maintains adequate disaster recovery and business continuity plans. However, its contingency plans are not tested routinely.

Claims Adjudication

AvMed has implemented many controls in its claims adjudication process to ensure that FEHBP claims are processed accurately.

Flash Audit Alert – Obstruction by Health Net of California

RANCHO CORDOVA, CALIFORNIA

Report No. 1C-LB-00-18-023

FEBRUARY 12, 2018

The OIG performs IT audits of all insurance carriers that participate in the FEHBP. These organizations contract with OPM to provide health insurance coverage for Federal employees, retirees, and their families. The objective of our IT audits is to ensure that the insurance carriers have controls in place to protect the confidentiality, integrity, and availability of highly sensitive protected health information (PHI) and personally identifiable information (PII) of FEHBP members.

Our IT audits primarily focus on the information systems that directly process and/or store FEHBP data. However, almost without exception, FEHBP carriers do not segregate FEHBP data from data for their other commercial and/or Federal customers. From a technical perspective, a control weakness on one system poses a threat to all other systems in the same logical and/or physical technical environment. Therefore, the scope of certain test work must include all parts of the organization's technical infrastructure that have a logical and/or physical nexus with FEHBP data.

From October 2017 through January 2018, we engaged in pre-audit discussions and planning with Health Net of California (Health Net), and two site visits were scheduled for this audit. The first site visit was January 22 - 26, 2018, and consisted of multiple interviews with subject matter experts to discuss Health Net's IT security controls. The second site visit was scheduled for February 12 - 16, 2018, to conduct appropriate tests of those controls. Although we completed the audit interviews during the first site visit, it subsequently became apparent that Health Net did not intend to cooperate with our testing. On February 7, 2018, we received an e-mail from the Health Net audit coordinator clearly stating that the company did NOT intend to comply with our requests. Specifically, that Health Net would NOT allow the OIG to conduct vulnerability and configuration management testing. Also, that Health Net would not provide the OIG with the artifacts required to perform testing related to Health Net's ability to effectively remove information system access to terminated employees and contractors.

**Health Net
Did Not Intend
to Cooperate
With Our
Testing**

Health Net's actions were in direct violation of the company's contract with OPM, and also disregarded the statutory authority of the OIG. Of greater concern, however, is that our auditors could not evaluate Health Net's IT security controls in the above two critical



areas. As a result, we are unable to attest whether Health Net is acting as a responsible custodian of critically sensitive PHI and PII of FEHBP members.

Note: Health Net has subsequently acquiesced to our requests and is allowing testing to commence as originally planned. The Plan also delivered the documentation it originally refused to provide. For additional information, see the "Message from the Acting Inspector General" at the beginning of this semiannual report.

Global Veterans Affairs Claims BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-16-021

FEBRUARY 28, 2018

We conducted a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from January 1, 2013, through October 31, 2015. Specifically, we identified claims from this period that were made to U.S. Department of Veterans Affairs (VA) medical providers where the amount paid to the provider was greater than or equal to the amount billed by the provider.

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions with regard to claims paid to the VA.

Veterans that are also enrolled in the FEHBP may use their FEHBP benefits at VA medical service providers (e.g., a VA hospital). Our audit identified claim payment errors that we believe are indicative of systemic problems with the BCBS Association's administrative procedures for processing FEHBP claims paid to VA medical providers. We are recommending several system and policy enhancements that would result in significant cost savings to the FEHBP.

Our audit concludes that the overall processing of FEHBP VA claims by the BCBS plans does not appear to comply with the terms of its contract with OPM and

Auditors Question \$58 Million in Health Benefit Charges Related to VA Claims

the Federal Acquisition Regulation. The BCBS Association and the BCBS plans lack the necessary controls to ensure that reasonable rates are paid to VA providers on behalf of the FEHBP. We determined that the Association and/or plans paid 77 percent of the VA claims reviewed during our audit at or above the full amount billed by the provider – even though they had the option to pay the claims at a lower rate. Specifically, the BCBS plans could have paid these claims using the plan's local "usual, customary, and reasonable" rate or by negotiating a lower payment rate with the VA.

This report questions \$58,023,161 in health benefit charges, the majority of which relate to the BCBS plans unreasonably paying VA claims.

Global Coordination of Benefits for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-16-062

MARCH 15, 2018

We conducted a limited scope performance audit of the FEHBP operations at all BCBS plans. The audit covered claim payments from December 1, 2015, through August 31, 2016. Specifically, we identified claims incurred on or after November 15, 2015, that were reimbursed from December 1, 2015, through August 31, 2016, and were potentially not coordinated with Medicare [referred to as coordination of benefits (COB)].

The objectives of our audit were to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits with Medicare.



For many years, we have had serious concerns with the efforts of the BCBS plans and the BCBS Association to implement corrective actions to prevent coordination of benefits claim payment errors. Our audits (performed annually since 2001) routinely show that the primary reason for coordination of benefits claim payment errors is the fact that BCBS plans fail to review and/or adjust a patient's prior paid claims when that member's Medicare enrollment information is subsequently obtained.

Although the BCBS Association has made several modifications to its claims adjudication system in an effort to reduce coordination of benefits errors, the results of this audit continue to indicate that these corrective actions have not had a substantial impact in reducing the amount of COB payment errors. Our audit determined that \$11,738,240 in COB overpayments from the FEHBP were paid in error over a nine-month period. Since 2004, the BCBS Association has allowed over \$167 million in coordination of benefits-related claim overpayments.

**The OIG
Has Questioned
\$167 Million
in COB-Related
Improper Payments
Since 2004**

The BCBS plans and the Association have not met their contractual obligation to proactively identify or retroactively adjust overpayments through a robust internal control program.

Considering the length of time that the BCBS Association has allowed these material errors to occur, the OIG does not believe that the improper payments were made in good faith. Therefore, we recommend that the entire questioned amount be returned to the FEHBP regardless of the plans' ability to recover the funds from the providers.

The BCBS Association had initiated recovery for \$5,231,401 of the claim overpayments prior to the start of this audit. This report questions the remaining \$6,506,839 in health benefit charges that were potentially not coordinated with Medicare.



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

OPM'S CONSOLIDATED FINANCIAL STATEMENT AUDITS

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States. OPM contracted with the independent certified public accounting firm Grant Thornton LLP (Grant Thornton) to audit the agency's consolidated financial statements as of September 30, 2017, and for the FY then ended. The contract requires that the audit be performed in accordance with Generally Accepted Government Auditing Standards (GAGAS) and the Office of Management and Budget (OMB) Bulletin No. 17-03, *Audit Requirements for Federal Financial Statements*, as amended.

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

Grant Thornton is responsible for, but is not limited to, issuing an audit report that includes:

- Opinions on the consolidated financial statements and the individual statements for the three benefit programs;
- A report on internal controls; and
- A report on compliance with certain laws and regulations.

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

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings, reviewing Grant Thornton's work papers, and coordinating the issuance of audit reports. Our review disclosed no instances where Grant Thornton did not comply, in all material respects, with GAGAS.

In addition to the consolidated financial statements, Grant Thornton performed the audit of the Closing Package Financial Statements as of September 30, 2017. The contract requires that the audit be done in accordance with GAGAS and the OMB Bulletin No. 17-03. The U.S. Department of the Treasury (Treasury) and the Government Accountability Office use the Closing Package in preparing and auditing the *Financial Report of the United States Government*.

OPM's FY 2017 Consolidated Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-17-028

NOVEMBER 13, 2017

Grant Thornton audited OPM's consolidated and consolidating financial statements, which comprise the consolidated and consolidating balance sheets as of September 30, 2017 and 2016, the related consolidated and consolidating statements of net cost and changes in net position, and the combined and combining statements of budgetary resources for



the years then ended, and the related notes to the consolidated and consolidating financial statements (collectively, the “financial statements”). Grant Thornton also audited the individual balance sheets of the Retirement, Health Benefits and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2017 and 2016, and the Programs’ related individual financial statements for those years. The Programs, which are essential to the payment of benefits to Federal civilian employees, annuitants, and their respective dependents, operate under the following names:

- Civil Service Retirement System;
- Federal Employees Retirement System;
- Federal Employees Health Benefits Program (FEHBP); and
- Federal Employees’ Life Insurance Program.

Grant Thornton reported that OPM’s consolidated financial statements and the Programs’ individual financial statements as of and for the years ended September 30, 2017 and 2016, were presented fairly, in all material respects, in conformity with U.S. Generally Accepted Accounting Principles. Grant Thornton’s audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

Grant Thornton identified one material weakness in the internal controls related to OPM’s information systems control environment. However, they did not identify any significant deficiencies.

Information Systems Control Environment

OPM is charged with the oversight and accountability for the governance of its information technology control environment, including general IT controls. During FY 2017, OPM made progress in strengthening controls over its information systems to address the material weakness over its information systems control environment reported in FY 2016. However, Grant Thornton’s FY 2017 testing again identified issues in both the design and operation of key controls. This includes recurring issues

**Information
Systems Control
Environment
Material Weakness
Reported in 2017**

that had been identified in prior years, as well as deficiencies new in FY 2017. The deficiencies in OPM’s information systems control environment in the areas of Security Management, Logical and Physical Access, and Configuration Management are considered, in aggregate, to be a material weakness.

OPM agreed to the findings and recommendations reported by Grant Thornton.

Grant Thornton’s report on compliance with certain provisions of laws, regulations, and contracts identified instances of non-compliance with the *Federal Financial Management Improvement Act of 1996 (FFMIA)*, as described in the material weakness, in which OPM’s financial management systems did not substantially comply with the Federal financial management systems requirements. The results of Grant Thornton’s tests of FFMIA disclosed no instances in which OPM’s financial management systems did not substantially comply with applicable Federal accounting standards and the United States Government Standard General Ledger at the transaction level.



OPM's FY 2017 Closing Package Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-17-029

NOVEMBER 13, 2017

The Closing Package Financial Statements are required to be audited in accordance with GAGAS and the provisions of the OMB's Bulletin No. 17-03. OPM's Closing Package Financial Statements comprise the: Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS) Reconciliation Report – Reclassified Balance Sheet as of September 30, 2017; the related GTAS Reconciliation reports – Reclassified Statement of Net Cost and Reclassified Statements of Operations and Changes in Net Position for the year then ended; and the related notes to the financial statements. The notes to the financial statements comprise the following:

- The GTAS Closing Package Lines Loaded Report, and
- Financial Report (FR) Notes Report (except for information in the FR Notes Report entitled "2016 – September," "Prior Year," "PY," "Previously Reported," "Line Item Changes," "Threshold," and the information as of and for the year ended September 30, 2016, in the "Text Data" of the FR Notes Reports).

**OPM's FY 2017
Closing Package
Statements Receive
Another
Clean Opinion**

Grant Thornton reported that OPM's Closing Package Financial Statements are presented fairly, in all material respects.

Grant Thornton noted no matters involving the internal control over the financial process for the Closing Package Financial Statements that are considered a material weakness or significant deficiency. In addition, Grant Thornton disclosed no instances of noncompliance or other matters that are required to be reported. The objectives of Grant Thornton's audits of the Closing Package Financial Statements did not include expressing an opinion

on internal controls or compliance with laws and regulations, and Grant Thornton, accordingly, did not express such opinions.

OPM's Data Submission and Compliance with the Digital Accountability and Transparency Act

WASHINGTON, D.C.

Report No. 4A-CF-00-17-033

NOVEMBER 9, 2017

The Digital Accountability and Transparency Act (DATA Act) was enacted on May 9, 2014, to expand the reporting requirements pursuant to the Federal Funding Accountability and Transparency Act of 2006. The DATA Act, in part, requires Federal agencies to report financial and award data in accordance with the established Government-wide financial data standards. In May 2015, OMB and Treasury published 573 data definition standards and required Federal agencies to report financial data in accordance with these standards for DATA Act reporting, beginning in January 2017. Once submitted, the data must be displayed on USASpending.gov for taxpayers and policy makers.

Our auditors completed a performance audit of OPM's DATA Act process and submission for the second quarter of FY 2017. The objectives of our audit were to assess (1) the completeness, timeliness, quality, and accuracy of second quarter FY 2017 financial and award data submitted for publication on USASpending.gov, and (2) OPM's implementation and use of the Government-wide financial data standards established by OMB and Treasury.

Our audit found that the second quarter FY 2017 financial and award data submitted by OPM was complete, timely, accurate, of adequate quality, and we identified no internal deficiencies that would affect the data submission. In addition, we verified each transaction to its source system data, and that the transactions were reported within 30 days of the quarter's end, as required by OMB's *Memorandum M-10-06, Open Government Directive*, dated April 6, 2010.



With respect to the data completeness, we estimated an error rate of 18.9 percent, with a margin of error of 4.33 percent. We estimated OPM's data accuracy error rate to be 1.29 percent, with a margin of error of 1.14 percent. *(Note – during our audit, we found errors that were attributable to agency-supplied information, as well as issues with the DATA Act Broker where OPM does not have control. The Federal Audit Executive Council DATA Act Working Group provided standard language for reporting purposes to address this concern.)*

While OPM met the objectives of the DATA Act, we noted the following opportunities for improvement:

- Summary-Level differences between data submission files A and B – OPM's gross outlay and obligations incurred amounts by program object class in File B did not agree to the gross outlay and obligations incurred amounts by Treasury Account Symbol in File A;
- Lack of effective and efficient standard operating procedures and control activities over the data submission process – The Office of the Chief Financial Officer did not provide proper guidance to all OPM offices involved in the data submission process prior to the May 9, 2017, implementation of its DATA Act requirements; and
- Lack of Effective and Efficient Controls over Data Submission Files A through F – We found 3 data accuracy errors and 44 blank data fields displayed in File D1.

OPM concurred with two of our recommendations and partially concurred with the third.

OPM's Award of a Credit Monitoring and Identity Theft Services Contract to Identity Theft Guard Solutions, LLC

WASHINGTON, D.C.

Report No. 4A-OO-00-17-035

FEBRUARY 28, 2018

In FY 2015, OPM experienced a cyber-attack incident where 21.5 million background investigation records of current, former, and prospective Federal employees and contractors were stolen. To mitigate the risk of fraud and identity theft, the Department of the Navy awarded a contract to Identity Theft Guard Solutions, LLC, doing business as ID Experts, to provide identity theft protection services for the affected individuals. On March 15, 2016, the Department of the Navy transferred the contract to OPM to perform administrative responsibilities. In December 2015, the United States Congress enacted the "Consolidated Appropriations Act, 2016," which requires OPM to provide complimentary identity protection coverage to affected individuals. On October 28, 2016, OPM awarded an identity theft services contract with ID Experts to comply with the Congressional mandate.

We conducted a performance audit to determine if OPM's Office of Procurement Operations awarded the credit monitoring and identity theft services contract to ID Experts in compliance with the Federal Acquisition Regulations (FAR) and OPM's procurement policies and procedures.

Our auditors identified the following two areas of noncompliance with the FAR and OPM's policies and procedures:



1. Incomplete Contract File – The Office of Procurement Operations did not comply with the FAR requirements and OPM's policies and procedures in awarding the ID Experts contract. Specifically, we identified the following:

- The acquisition plan, market research plan, technical evaluation plan and various other contractual documents were incomplete and/or unapproved by the Office of Procurement Operations' management and OPM's Office of the General Counsel;
- The System for Award Management was not referenced until after the award of the General Services Administration (GSA) order;
- The Contracting Officer's Representative was not designated until after the award of the GSA order;
- The credit monitoring and identity theft services contract did not go through the Office of Procurement Operations' Contract Review Board process; and
- There were data entry errors entered into the Federal Procurement Data System.

2. Oversight Review Controls Need Strengthening – Based on our audit findings, we have concluded that the Office of Procurement Operations needs to strengthen their review controls over the procurement process.

The Office of Procurement Operations agreed with both of our recommendations. Without a complete and accurate history of the actions taken to award the contract, it is impossible to know whether adherence to all FAR requirements would have resulted in an award of the contract to an entity other than ID Experts.

OPM's Common Services

WASHINGTON, D.C.

Report No. 4A-CF-00-16-055

MARCH 29, 2018

We conducted a performance audit on OPM's Common Services with the objectives of (1) assessing the methodology used by OPM's Office of the Chief Financial Officer (OCFO) to develop the Common Services cost and (2) determining if OPM's Common Services cost was accurately computed.

OPM's Common Services is an internal fund for its administrative and leadership program offices. The OCFO's Budget and Performance Office is responsible for administering OPM's Common Services, which includes identifying the Common Services program's budgets, computing the financing distribution, and billing OPM's four funding sources: OPM Discretionary, OIG, Mandatory Trust Fund, and Revolving Fund.

We determined that the OCFO's common services methodology is valid and reasonable; however, we identified the following three areas where OPM can improve its internal controls over Common Services:

- Data Entry Errors – We identified two data entry errors in the Common Services distribution calculation;
- Lack of Supporting Documentation – The OCFO could not produce documentation to support (1) that the Director approved the FY 2017 Common Services cost of \$105,101,530; (2) a change in the Human Resources Solutions office's Common Services January billing; and (3) how they determined the amount charged to the OIG; and
- Common Services Budget Levels Are Not Transparent – The OCFO's FY 2017 Common Services bill did not identify the "Unallocated" amount, of \$3,277,281, which is set aside for emergency purposes.

In response to our draft report, OPM concurred with three of our five recommendations.



Special Audits

In addition to health insurance and retirement programs, OPM administers various other benefit programs for Federal employees which include:

- *Federal Employees' Group Life Insurance (FEGLI) Program;*
- *Federal Flexible Spending Account (FSAFEDS) Program;*
- *Federal Long Term Care Insurance Program (FLTCIP); and*
- *Federal Employees Dental and Vision Insurance Program (FEDVIP).*

Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers are in accordance with the contracts and applicable Federal regulations. Additionally, our staff performs audits of the Combined Federal Campaign (CFC) to ensure that monies donated by Federal employees are properly handled and disbursed to charities according to the designations of contributing employees, and audits of Tribal enrollments into the FEHBP.

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Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. for Contract Years 2012 through 2014

SCOTTSDALE, ARIZONA
Report No. 1H-01-00-16-044
OCTOBER 2, 2017

Mail Handlers Benefit Plan (MHBP) participates in the FEHBP and contracted with a Pharmacy Benefit Manager (PBM), CaremarkPCS, L.L.C. (Caremark), 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 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. PBMs are used to develop, allocate, and control costs related to the pharmacy claims program.

The contract outlines transparency standards that require PBMs to provide pass-through pricing based on their cost. Our responsibility is to review the performance of Caremark to determine if the Plan charged costs to the FEHBP and provided services to its members in accordance with the OPM contract, the agreement between the Plan and Caremark, and applicable Federal regulations.

Our audit consisted of a review of administrative fees, claim payments, fraud and abuse reporting, performance guarantees, and pharmacy rebates related to the FEHBP for contract years 2012 through 2014.

**\$1.5 Million in
Pharmacy Claims
were Paid for 302
Overage Dependents
Whose Eligibility
was Unsupported**



We did not find any deficiencies during our review of the administrative fees, fraud and abuse program, performance guarantees, and manufacturer rebates. However, during our review of claim payments, we determined that MHBP needs to strengthen its procedures and controls related to dependent eligibility. Specifically, our audit identified that MHBP paid \$1,562,397 in pharmacy claims for 302 dependents age 26 or older whose eligibility to participate in the FEHBP could not be supported.

MHBP partially agreed with our recommendations.

Federal Employees Dental and Vision Insurance Program Operations as Administered by Humana Dental for Contract Years 2014 and 2015

ROSWELL, GEORGIA

Report No. 1J-OJ-00-17-016

FEBRUARY 6, 2018

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 established a supplemental dental and vision benefits program for Federal employees, retirees, and their eligible family members. The Federal Employees Dental and Vision Insurance Program (FEDVIP) carriers sign fixed price with prospective price redetermination contracts with OPM to provide dental and vision insurance services for a period of seven years. OPM awarded a contract to Humana (Plan) to administer dental benefits under the FEDVIP.

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

Humana Overstated Claim Projections in Developing Premium Rates for FEDVIP

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 the audit was to determine whether costs charged to the FEDVIP and services provided to its members for contract years 2014 and 2015 were in accordance with the terms of the contract and applicable Federal regulations.

The results of our review determined that the Plan needs to strengthen its procedures and controls related to its annual accounting statements, claims processing, fraud and abuse program, performance guarantees, and rate proposals. Specifically, our audit identified the following deficiencies that require corrective action:

- The Plan overstated income taxes applied to the FEDVIP for 2014 and 2015;
- The Plan overpaid premium tax in 2014 by \$555,120;
- The Plan failed to terminate one member in a timely manner and did not have controls in place to recover overpayments from ineligible members;
- The Plan failed to coordinate some benefits with other insurance providers;
- The Plan paid claims to two debarred providers;
- The Plan failed to meet several performance standards that it guaranteed for 2014 and 2015; and
- The Plan overestimated claims projections when negotiating the contract rates with the OPM.

Enforcement Activities

Investigative Cases

The U.S. 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 Federal Employees' Group Life Insurance Program. These programs cover over nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$140 billion annually. The majority of our Office of Investigations 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 conducted by OPM's National Background Investigations Bureau.

During the reporting period, our office opened 51 cases and closed 209 cases. Our investigations led to 28 arrests, 37 indictments and informations, 20 convictions, and \$7,808,415 in monetary recoveries to OPM-administered trust funds. Our investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$77,122,179 in criminal, civil, and administrative recoveries and fines, which are returned to the General Fund of the Treasury. For a statistical summary of our office's investigative activity, refer to the table on page 37.

HEALTH CARE FRAUD

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal and civil investigations are critical to protecting Federal employees, annuitants, and their families who participate in the FEHBP. Of particular concern are cases that involve harm to patients, pharmaceutical fraud, 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 Statute 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 U.S. 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. Attorneys' 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, OIG special agents work closely with our auditors when fraud issues arise during audits of the insurance carriers. They also coordinate with the OIG's Administrative Sanctions Program when investigations of FEHBP health care providers reveal evidence of violations that may warrant suspension and/or debarment from participating in the FEHBP.

The following investigative cases represent some of our activity during the reporting period.

HEALTH CARE FRAUD CASES

Genetic Testing Company Agrees to Pay \$11.4 Million to Settle Allegations of Improper Billing

In March 2018, Natera, a California genetic testing company, agreed to pay \$11.4 million, plus applicable interest, to resolve allegations that it used improper billing codes from 2013 through 2016 in order to receive higher reimbursement rates. Natera used an incorrect Current Procedural Terminology (CPT) code that misrepresented the services rendered in order to avoid expending administrative resources and delayed payments. Clear guidance in the TRICARE, a health care program of the U. S. Department of Defense Military Health System, and the American Medical Association CPT manuals identified the appropriate CPT code to use for the Panorama test. In addition, the number of units billed by Natera under the incorrect CPT code appeared arbitrary and designed to meet revenue expectations as opposed to actual services being performed.

Of the total settlement amount, OPM will receive single damages of \$580,284 plus lost investment income of \$47,463. We investigated this case jointly with the Defense Criminal Investigative Service (DCIS) and the Department of Health and Human Services (HHS) OIG. We were notified of this case in March 2015 by the DOJ via a *qui tam* lawsuit filed under the False Claims Act.

*A **qui tam** lawsuit may be filed on behalf of the Federal Government if an individual has knowledge of a person or company 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 potentially receives 15-25 percent of the recovery if the Government interceded; or 25-30 percent if the Government did not intercede.*

Medical Supplier Agrees to Pay \$1.3 Million to Settle Civil Fraud Case

In April of 2014, the DOJ notified us of a False Claims Act *qui tam* lawsuit alleging that Nationwide Medical (NWM) was involved in billing for unnecessary continuous positive airway pressure supplies. Our investigation determined that NWM was billing Healthcare Common Procedure Coding System (HCPCS) codes A7031 (face mask interface, replacement) and A7032 (cushion for use on nasal mask interface, replacement only) unnecessarily from January 2006 through July 2014. The FEHBP's total exposure for these two HCPCS codes was \$2,031,339.

In October 2017, the relator and NWM agreed to settle the allegations for \$1,333,333. The relator received 27.5 percent of the settlement and the remainder would be divided between Medicare, the FEHBP, and TRICARE by percentage of loss. The settlement was signed in January 2018 and states that NWM violated the False Claims Act by submitting or causing to be submitted, false claims for payment by billing for replaceable mask cushions but only shipping replaceable nasal flaps, and shipment of replacement supplies without proper documentation.

The FEHBP received \$126,814 from the settlement. We worked this case jointly with DCIS and the HHS OIG.



Acupuncturist Pleads Guilty to Mail Fraud

In December 2014, the BCBS Association notified our office of an acupuncturist it believed was billing for services that were not rendered. Our investigation found that FEHBP patients were being billed for services performed on days the provider was not even in the country. During interviews, patients stated that they received facials and massages from the provider, not acupuncture or any other covered service. In April 2017, the provider confessed to billing for services not rendered. In June 2017, the provider pleaded guilty to mail fraud. She was sentenced in October 2017 to 12 months and one day of incarceration, 24 months of supervised release, and ordered to pay restitution in the amount of \$535,143, of which the FEHBP will receive \$343,320.

We worked this case with the U. S. Department of Labor – Employee Benefits Security Administration.

in false and fraudulent claims and the FEHBP paying over \$220,000. The pharmacist was sentenced on March 9, 2018 to 17 years imprisonment followed by three years of supervised release and ordered to pay restitution of \$31,259,252. The FEHBP is expected to receive \$234,333.

This case was investigated by DCIS, the U.S. Postal Service OIG, the Food and Drug Administration, and the U.S. Department of Veterans Affairs (VA) OIG, and our office.

Federal Retiree Found Guilty of Health Care Fraud

In June 2012, we received a referral from the BCBS Association alleging that a Federal retiree was using his medical benefits to obtain a synthetic opioid, Nalbuphine (Nubain), at numerous hospital emergency rooms across multiple states. Our investigation found that while receiving two injections of Nubain per week from his primary care physician, the Federal retiree sought additional injections at emergency rooms throughout Virginia, West Virginia, North Carolina, South Carolina, Georgia, and Florida, which resulted in more than \$824,000 being paid by the FEHBP for services rendered at those emergency rooms. In order to facilitate receiving the injections, the Federal retiree claimed to have a migraine headache and made several false statements and concealed material information.

A Federal indictment was filed in the U.S. District Court for the Western District of Virginia charging the Federal retiree for knowingly and willfully devising a scheme and artifice to defraud the FEHBP. The Federal retiree subsequently pleaded guilty, and in November 2017, was sentenced to 20 months incarceration followed by 36 months of supervised release, and ordered to pay restitution to the FEHBP in the amount of \$549,607.

We worked this case jointly with the Federal Bureau of Investigation (FBI).

Florida Jury Finds Pharmacist Guilty of Health Care Fraud

In January 2015, DCIS notified us of a Pompano Beach, Florida, pharmacy they were investigating for possible health care fraud. The pharmacist and his right-hand man at the pharmacy entered into a vast conspiracy with marketers who paid physicians to write prescriptions for expensive topical medications that cost up to \$17,000 a bottle. The pharmacist and the co-conspirators agreed to automatically refill the prescriptions, sending numerous refills to patients who did not request them, while not charging a co-pay in hopes that the patients would not bother to return them.

On September 5, 2017 in the Southern District of Florida, the pharmacist was found guilty of health care fraud and other related charges. Through the conspiracy, the pharmacy billed over \$37 million from July 2013 through May 2015 to TRICARE and the FEHBP, with TRICARE paying out over \$30 million



Houston Surgery Center Agrees to Pay \$1.5 Million to Settle Allegations of False Claims

A *qui tam* lawsuit was filed in U.S. District Court for the Southern District of Texas in 2013 alleging that from April 2007 through November 2014, North Houston Endoscopy & Surgery submitted, or caused to be submitted, false claims for colonoscopies. The relator alleged that the facility's cleanliness was substandard and that certain colonoscopy procedures were not performed properly. Specifically, the lawsuit claimed that in the interest of time, the physicians would not always examine the entire colon and would sometimes spend as little as two minutes on a colonoscopy. The lawsuit further alleged that physicians performed procedures at the Center so quickly that they were essentially worthless. By failing to take the necessary amount of time to closely examine the colon, precancerous lesions could be missed. Lastly, it was alleged that the surgery center did not follow established guidelines for sanitation. North Houston Endoscopy & Surgery and the relator agreed to settle the allegations in October 2017. The surgery center will pay the Government \$1,575,000 with OPM receiving \$176,400.

We worked this case with the HHS OIG.

Health and Allied Service Provider Agrees to Pay \$550,000 to Settle Health Care Fraud Allegations

In February 2014, the DOJ notified us of a *qui tam* lawsuit filed in the Eastern District of Pennsylvania against Bromedicon, a medical provider that specializes in Intra Operative Neurological Monitoring (IONM). This lawsuit alleged Bromedicon failed to provide a licensed physician to perform IONM services for certain surgeries between January 1, 2011 and December 31, 2015, causing false claims to be submitted for reimbursement to Medicare, Medicaid, TRICARE, and the FEHBP.

Bromedicon's business was to provide real-time remote IONM during high-risk brain and spinal surgeries. The purpose of IONM is to monitor the

integrity of neurological structures during surgery. This allows the surgeon to avoid causing unintended damage to such structures and, in some cases, can allow the surgeon to be more aggressive. A technician in the operating room affixes electrodes to the patient, which then transmit data to a remote monitoring physician who communicates with the technician throughout the surgery via electronic chat. The person monitoring the surgery remotely must be a licensed physician for IONM to be reimbursable.

Our investigation confirmed that the surgeries purportedly monitored by Bromedicon were either: (a) not monitored at all, (b) only monitored in part, or (c) were monitored in whole or part by Bromedicon's Medical Director – a foreign medical school graduate with no license to practice medicine in the United States. In many of these cases, Bromedicon submitted claims using the names of licensed physicians employed by Bromedicon, but who had not monitored the entire case. Between January 1, 2011 and December 31, 2015, Federal programs paid Bromedicon \$1,006,068 for professional IONM services which were found to meet the criteria for the alleged false claims. A negotiated settlement was reached with Bromedicon in February 2017 for \$550,000. Of that amount, the FEHBP will receive \$44,173.

This investigation was worked jointly with the HHS OIG and DCIS.

Illinois Jury Convicts Chiropractor of Health Care Fraud

The FBI referred a case involving allegations that a chiropractor billed for services not rendered to BCBS of Illinois, an FEHBP carrier, who then forwarded the allegations to our office in January 2016. Our investigation verified that this provider was billing for services he did not provide. Specifically, he was billing for services purportedly rendered to patients at his Illinois-based clinic while he was out of the state. Additionally, he was billing for services ostensibly provided to beneficiaries after their dates of death.

In October 2017, a Federal grand jury issued an 18-count indictment against the provider in the



U.S. District Court for the Northern District of Illinois charging him with committing health care fraud on eighteen separate dates between 2013 and 2015. In February 2018, the District Judge sentenced the provider to 60 months imprisonment, followed by 12 months of supervised release. Additionally, he was ordered to pay restitution totaling \$4,087,735. The FEHBP portion of the restitution totaled \$311,314 and was included in the amount payable to BCBS of Illinois which totaled \$2,256,651.

We worked this case jointly with the FBI and the HHS OIG.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments cease 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 annuity benefit payments by an unentitled recipient. However, retirement fraud can also include incidents of elder abuse.

Our investigators use 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 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.

RETIREMENT FRAUD CASES

Annuitant's Nephew Pleads Guilty to Theft of Government Property

The Social Security Administration (SSA) OIG referred this case to us in June 2014 where post-death benefits were paid from the SSA, the VA, and OPM. The case was discovered as a result of SSA's "centenarian project," where SSA reviews records of individuals who are a certain age and attempted to locate them to confirm that they are still alive. The

annuitant in this case died on September 6, 1995. Unaware of her death, SSA, VA, and OPM continued to deposit annuity payments totaling \$363,960 into her bank account until July 2014. The investigation identified the annuitant's nephew as the subject who received the benefits and converted them to his personal use. In February 2017, he was indicted in the Central District of California on 15 counts of theft of Government property and 1 count of Social Security fraud by concealment. He pleaded guilty in December 2017 and in March 2018 was sentenced to 36 months of probation and ordered to pay full restitution in the amount of \$363,960. OPM's portion of the restitution was ordered in the amount of \$109,497.

The investigation was worked jointly by our office and the VA and SSA OIGs.

OPM Overpays Remarried Survivor Annuitant

In February 2017, our office identified a marital record in Lexis Nexis showing that on October 13, 1997, a survivor annuitant had remarried prior to age 55 and was still receiving a survivor annuity. If a survivor annuitant remarries prior to age 55, they are not eligible to continue receiving survivor benefits unless they were married to their prior spouse for 30 years or longer. The second marriage ended in divorce on November 9, 1999. OPM continued the survivor's annuity payments through February 1999. The survivor annuity file contains a computation of the overpayment for the period October 1, 1997 through February 28, 1999 and a copy of the Notice of Debt Due (RI 34-3) that was mailed to the annuitant by OPM. The file shows an L04 code (deduction withdrawn for due process) on November 13, 1999, but the installments were never withheld to collect the \$10,163 overpayment.

In addition, the annuitant married again on January 12, 2008. This marriage ended in divorce on March 11, 2009. OPM did not terminate her survivor annuity during the period of this remarriage either, resulting in an additional \$11,112 overpayment. The annuitant notified OPM of both of her remarriages and divorces, but OPM failed to take corrective action to stop and recover the overpayments. Our office notified OPM's



Retirement Services office of the errors made on this case and asked them to take appropriate corrective action. On October 3, 2017, Retirement Services sent the annuitant a letter stating the \$21,275 overpayment would be collected in 85 installments beginning with the January 2018 monthly annuity payment.

Survivor Annuitant's Daughter Pleads Guilty to Stealing Annuity Payments

In June 2017, we received a request for assistance from the SSA OIG regarding a death investigation of a CSRS survivor annuitant. The joint investigation showed that the annuitant was overpaid \$24,458 in SSA funds and \$96,516 in CSRS annuity funds for a total overpayment of \$120,974. The investigation determined that the annuitant's daughter failed to report her mother's death and utilized the funds issued to her mother after her mother's death for her personal use.

In March 2018, the annuitant's daughter pleaded guilty to Theft of Public Funds in the U.S. District Court for the Southern District of Ohio. She was sentenced to three years of probation with the first ten months to be served in home detention, and ordered to pay restitution in the amounts of \$24,458 to SSA and \$96,516 to OPM.

Annuitant's Son Pleads Guilty to Stealing Annuity Payments

In April 2016, we received a fraud referral from OPM's Retirement Inspections office regarding a deceased annuitant's improper payments. The annuitant was receiving both annuity and survivor annuity payments. The annuitant died in June 2012, and OPM was never notified of her death and the annuity and survivor annuity payments continued being deposited into her checking account through March 2016, resulting in an overpayment of \$142,491. Our investigation determined that the son of the deceased annuitant forged the annuitant's name on numerous checks that he wrote to himself from the account where the monthly annuity payments were deposited.

In March 2017, the annuitant's son pleaded guilty to three counts of theft of government property in the U.S. District Court of Maryland and was sentenced in October 2017 to three months' home detention followed by 48 months' probation, and ordered to pay \$142,491 in restitution.

Daughter of Deceased Survivor Annuitant Pleads Guilty to Stealing Annuity Payments

This case, identified through a proactive project by our Investigative Support Group (ISG), showed that the January 31, 2001, death of a survivor annuitant was never reported to OPM and OPM continued to make monthly direct deposits into the survivor annuitant's bank account through May 2013. We identified a total of \$84,558, that was paid to the survivor annuitant's bank account after her date of death. The investigation found that between January 31, 2001 and June 27, 2013, the deceased annuitant's daughter voluntarily, intentionally, and knowingly converted her mother's survivor annuitant retirement payments for her own use. The daughter initially denied any wrong doing; however, during a second interview with our special agents, admitted taking the money.

On October 26, 2017, the annuitant's daughter pleaded guilty in the U.S. District Court of Minnesota to Theft of Government Funds and on February 20, 2018, was sentenced to six months of house arrest, 36 months of probation, and ordered to pay OPM restitution in the amount of \$84,558.

Survivor Annuitant's Daughter Pleads Guilty in Guam to Stealing Annuity Payments

We received a fraud referral from OPM's Retirement Inspections office regarding a survivor annuitant's May 6, 1997 death which was not reported to OPM. OPM continued directly depositing monthly annuity payments into the annuitant's savings account through March 2015. The total overpayment in this case was \$297,170. OPM recovered \$1,756 through Treasury's reclamation process, leaving a balance due of \$295,414.



Through interviews and a forensic review of the bank records, we identified the daughter of the deceased annuitant as the person responsible for converting the annuity funds to her own use. On September 28, 2016, the daughter was interviewed and admitted to the theft of her mother's annuity after her mother's death. On August 21, 2017, the daughter pleaded guilty to Theft of Government Money in the District Court of Guam and was sentenced to 18 months incarceration, three years supervised release, and restitution of \$295,414.

The FBI and our office worked jointly on this investigation.

Annuitant's Granddaughter Pleads Guilty in Florida to Stealing Annuity Payments

We received a referral from the SSA OIG alleging that the granddaughter of a deceased annuitant received and converted to her own use benefits issued to her deceased grandmother by SSA and OPM. During an interview with our special agents in January 2017, the granddaughter stated that she was aware that what she was doing was wrong, and she knew that the benefits were for her grandmother. She said she did not notify OPM or SSA of her grandmother's death because she relied on those payments to support herself. The loss to the U.S. Government totaled \$75,272, with \$44,815 attributable to SSA and \$30,457 attributable to OPM.

On September 5, 2017, the granddaughter pleaded guilty in the U.S. District Court for the Middle District of Florida to Theft of Public Money, Property or Records. She was sentenced on November 29, 2017 to 24 months of probation and ordered to pay restitution in the amount of \$75,272 to the Government with OPM receiving \$30,457 and SSA receiving \$44,815.

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.

The National Background Investigations Bureau (NBIB), which was established on October 1, 2016, conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. NBIB conducts 95 percent of all personnel background investigations for the Federal Government. With a staff of over 9,900 Federal and contract employees, NBIB processed over 2.5 million background investigations in FY 2017. 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 provide this necessary investigative oversight for the NBIB, as 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.

Nine Revolving Fund complaints and investigations were opened during the reporting period and 21 cases were closed.



INTERNAL AND ADMINISTRATIVE INVESTIGATIONS

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations of fraud, waste, abuse, or mismanagement at OPM. During the reporting period we closed ten internal cases and opened no new internal cases.

The following represents our activities during the reporting period.

Former Executive Director of Non-Profit Organization Found Guilty of Using CFC Funds for Personal Use

In November 2012, we received a case referral from the OPM's CFC program alleging that a former Executive Director for AIDS Global Action (AGA), a non-profit organization and former Federation of the CFC, failed to properly distribute all CFC funds to the members of the AGA federation. AGA's mission was to address the needs of people with HIV or AIDS. AGA received charitable donations from the CFC and functioned as a pass-through for donations to its member charities. Our investigation determined that the former Executive Director for AGA fraudulently transferred AGA funds electronically and wrote checks from the AGA Federal bank account and deposited them into his personal bank accounts for his own personal use and gain.

In December 2016, the former Executive Director for AGA pleaded guilty in the U.S. District Court for the District of Columbia to one count of Interstate Transportation of Stolen Property and one count of Aiding & Abetting and Causing an Act to be Done. In December 2017, he was sentenced to 18 months of incarceration followed by three years of supervised release, and ordered to pay \$385,564 in restitution to the affected former AGA federation members that remain active.

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 Website at <https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>, along with an online complaint form that allows the complainant to remain anonymous. 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 1,233 hotline inquiries during the reporting period, and closed 1,162. The table on page 38 reports the summary of hotline activities including telephone calls, emails, and letters.

Non-Hotline Inquiries Received

As a result of our partnerships and strategic outreach efforts, our office receives allegations which result in our initiation of inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance impacting OPM programs and operations.

During this reporting period, we received 794 inquiries. Of those inquiries, 751 were related to health care fraud, 25 involved retirement fraud, 14 pertained to OPM's Revolving Fund programs, and the remaining 4 involve allegations of internal misconduct. These efforts may potentially evolve into formal investigations.



We believe that these inquiries 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

In March 2013, OPM implemented a suspension and debarment program, which is separate from the OIG's Administrative Sanctions Program of FEHBP health care providers. The OPM 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 two cases to the agency for debarment action, for a total of 112 referrals since the inception of the program. The OIG also referred two cases to the agency for suspension action. OPM issued no suspension or debarment letters during this reporting period.

The majority of cases we have referred for debarment action were former NBIB employees and contractors. Most of these former NBIB employees and contractors were referred to us through NBIB's 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, our Office of Investigations also referred 12 cases involving health care providers to the OIG's Administrative Sanctions Group for potential suspension or debarment from the FEHBP.



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 35,427 active debarments and suspensions from the FEHBP.

During the reporting period, our office issued 577 administrative sanctions – including both debarments and suspensions – of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 2,296 sanctions-related inquiries.

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 cited 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.*

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.

Administrative Sanctions serve a protective function for the FEHBP and the Federal employees, annuitants, and dependents who obtain their health insurance coverage under the FEHBP. The following cases highlight the importance of the Administrative Sanctions program in protecting FEHBP enrollees from health care providers who have jeopardized patient safety, or obtained fraudulent payment of FEHBP funds.

The following represents our administrative sanctions activities during the reporting period.

New Jersey Counselor Debarred After Criminal Conviction for Health Care Fraud and Sexual Assault

In November 2017, we debarred a New Jersey social worker after he was convicted of health care fraud and sexual assault by the Superior Court of New Jersey, Sussex County. The social worker was a licensed professional counselor in New Jersey specializing in child and adolescent therapy. The social worker had been arrested and charged with the following:

- 3 counts of Criminal Sexual Assault, victims less than 13 years;
- 3 counts of Endangering the Welfare of Children; and
- 38 counts of Health Care Claims Fraud.

The social worker subsequently pleaded guilty to 8 counts of second-degree sexual assault and 1 count of second-degree health care claims fraud and was sentenced to 10 years in prison.



His arrest followed an investigation that began after parents of his patients had contacted the Passaic County Prosecutor's Office with allegations of child molestation and insurance fraud. In his plea agreement, the social worker admitted to touching 8 children under the age of 13 between August 2011 and November 2015. In addition, the social worker admitted that during that same time frame, he submitted about \$650,000 in insurance claims for services he did not provide. He held group counseling sessions, and then charged the insurance companies for individual therapy sessions for the same date of service.

Under the FEHBP administrative sanctions statute, such convictions constitute a mandatory basis for debarment. We imposed a ten-year term of debarment. This case was referred by our Office of Investigations.

Pennsylvania Physician Debarred for Overprescribing Opioids and Narcotics and Threatening Law Enforcement Personnel

On March 1, 2018, we debarred a physician for overprescribing narcotics and threatening Federal law enforcement personnel. On September 15, 2017, the Commonwealth of Pennsylvania State Board of Medicine (Board) temporarily suspended the license of an internal medicine specialist licensed in Pennsylvania, and who also owned nine urgent care facilities. The physician was under investigation by the Drug Enforcement Administration (DEA), the FBI, the Internal Revenue Service (IRS), and other Federal and local law enforcement agencies for numerous civil and criminal charges, primarily in connection with overprescribing pain medication including opioids and running "pill mills" in Pennsylvania.

The FBI/DEA referred this case to our Office of Investigations and we initiated a joint investigation with these agencies. The joint investigation revealed the following:

- In July 2015, Federal and local law enforcement agents raided the physician's urgent care centers in Philadelphia and the Pennsylvania suburbs for illegally selling prescriptions;

- The U.S. Department of Labor subpoenaed records from the physician's clinics as part of an investigation of wages and overtime fraud; and
- The IRS served him with a \$2.8 million lien.

Further, U.S. Marshals went to the physician's home to deliver a bench warrant for a Federal civil suit. The physician resisted and went on a profanity laced tirade verbally assaulting and threatening the Marshals. After conducting a search of the physician at a Federal building, the Marshals found a loaded .380 pistol concealed in the physician's jacket.

On September 1, 2017, a complaint was filed against the physician in the U.S. District Court for the Eastern District of Pennsylvania. He was charged with knowingly and intentionally making a false statement to a Federal officer. A Federal judge found that he was a danger to the community and signed the emergency petition to have his license temporarily suspended.

The Pennsylvania Medical Board found that he was an immediate and clear danger to the public, and, in accordance with the Medical Practice Act, temporarily suspended his license.

The physician was also indicted on one count of threatening a law enforcement officer with the intent to impede, intimidate, and interfere with the officer while engaged in the performance of his official duties. He is currently in prison awaiting trial.

Under the regulations, we may debar health care service providers from participating in the FEHBP if their license to provide a health care service has been revoked, suspended, restricted, or not renewed by a State licensing authority for reasons relating to the provider's professional competence, professional performance or financial integrity. Our debarment of the physician is for an indefinite period pending full reinstatement of the physician's medical license. In addition, based on ownership and control, we debarred the physician's nine urgent care facilities, which are all located in Pennsylvania.



Michigan Physician Debarred for Substandard Care in Overprescribing Opioids

In November 2017, we debarred an internal medicine physician after the Michigan Board of Medicine, Department of Licensing and Regulatory Affairs Division suspended her license for incompetence, substandard care, and negligence. The Michigan Board of Medicine found that the physician was recklessly prescribing controlled substances and endangering the public health, safety, and welfare. The investigation found the following:

- The physician wrote 12,677 prescriptions for controlled substances for the 2-year period that ended August 31, 2016;
- The physician's prescriptions were for commonly abused controlled substances, such as oxycodone, hydrocodone, and alprazolam;
- The physician's medical files failed to include adequate documentation of patient history or the prescribed medication treatment;
- The physician did not provide medical assessments to determine risks of substance abuse or opioid tolerance; and
- The physician failed to obtain sufficient patient history to justify the medication treatment.

The U.S. District Court for the Eastern District of Michigan indicted the physician on seven counts of Unlawful Distribution of Controlled Substances for prescribing oxycodone and hydrocodone without a legitimate medical purpose. The physician was subsequently charged with Conspiracy to Unlawfully Distribute Controlled Substances and Prohibited Acts for conspiring to prescribe medically unnecessary controlled substances in exchange for cash payments and other remuneration.

The Michigan Medical Board discovered that the physician continued to authorize prescriptions for controlled substances after her indictment.

Our debarment of the physician is for an indefinite period pending full reinstatement of the physician's medical license. In addition, based on ownership and control, we debarred the physician's medical clinic, which was also used in committing the fraudulent activities.

Evaluations Activities

The Office of Evaluations (OE) provides an alternative method for conducting independent, credible, and thorough reviews of OPM's programs and operations to prevent waste, fraud, and abuse. OE quickly analyzes OPM concerns or issues that need immediate attention by using a variety of review methods and evaluation techniques. The work by OE is completed in accordance with the Quality Standards for Inspection and Evaluation (Blue Book) published by the Council of the Inspectors General on Integrity and Efficiency. OE reports provide OPM management with findings and recommendations that will assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

The following represents our evaluations activity during the reporting period.

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OPM's Retirement Services Imaging Operations

WASHINGTON, D.C.

Report No. 4K-RS-00-17-039

MARCH 14, 2018

At the request of OPM's Associate Director of Retirement Services, we initiated an evaluation of the Retirement Services' imaging operations. The objectives of our evaluation were to determine: (1) the efficiency of the processor imaging documents into its Electronic Document Management System; and (2) the effectiveness of this process for end users.

Retirement Services began imaging Federal employees' retirement records in January 2012 in order to address the limited record storage space and to transition to a paperless system.

We determined that the process for imaging documents into its Electronic Document Management System was efficient and end users felt that the images were beneficial to accurately complete retirement application packages. However, we issued the following recommendations for corrective actions:

- Update policies and procedures to reflect current operations;
- Conduct quality assurance audit of its imaged documents; and
- Develop performance measures to assess the effectiveness of its imaging operations.

Legal and Legislative Activities

Under the Inspector General Act of 1978, as amended, each statutory Inspector General must obtain legal advice from a counsel either reporting directly to the Inspector General or another Inspector General. The Office of Legal and Legislative Affairs advises the Inspector General and other OIG components on legal and regulatory matters, as well as develops and reviews legislative proposals to prevent and reduce fraud, waste, and abuse in OPM programs and operations.

The Office of Legal and Legislative Affairs issued the following management advisory during the reporting period.

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OPM's Non-Public Decision to Prospectively and Retroactively Re-Appportion Annuity Supplements

WASHINGTON, D.C.

Report No. L-2018-1

FEBRUARY 5, 2018

The OIG reviewed OPM's recent decision that reversed the way OPM apportions a retirement annuity based on a state court-ordered former spouse's marital share. The OIG initiated its review after receiving a complaint from the Federal Law Enforcement Officers Association (FLEOA). FLEOA raised concerns that OPM's nonpublic change was made without prior notice and is contrary to established law and practice.

For almost 30 years, OPM applied the state court-ordered marital share to the Basic Annuity (also known as the gross monthly annuity) only and not also to the Annuity Supplement. The Annuity Supplement is a supplemental annuity received by Law Enforcement Officers (LEOs) and certain other persons (such as Members of Congress) who retire earlier than when eligible for Social Security benefits. OPM previously considered the Annuity Supplement to be a Social Security-type benefit and thus not allocable as between former spouses. As a result, OPM did not include the Annuity Supplement in the calculation of annuity benefits to be paid to a former spouse, except under certain circumstances where the state court order expressly addressed the Annuity Supplement.

In July 2016, OPM started applying the state court-ordered marital share to both the Basic Annuity and the Annuity Supplement, even in cases where the state court order did not address the Annuity Supplement. However, OPM did not provide any public notice that it now considered the Annuity Supplement to



be allocable. Instead, retirees and the former spouses learned of OPM's decision only when their annuity amounts changed – many years after the parties had divorced, after a state court had ordered a former spouse's marital share, and after OPM had accepted the state court order for processing.

In addition, OPM applied this new interpretation retroactively to the date when the retiree started receiving an Annuity Supplement, resulting in a debt due from the retiree to the former spouse. Moreover, OPM's new policy improperly changes previously litigated final state court orders without notice to annuitants.

The OIG concluded that the language of the provision at issue – 5 U.S.C. § 8421(c) – does not mandate OPM's new reinterpretation. Instead, the OIG believes that the agency may not adopt or apply this change in policy without undergoing notice and comment rulemaking. Finally, we also concluded that OPM may not give its new interpretation retroactive effect.

The OIG recommended that OPM cease implementing the new policy and take all appropriate steps to make whole those retired LEOs whose annuity was impacted by the agency's reinterpretation. Finally, we recommended that OPM determine whether it has a legal requirement to make its updated guidance documents on this matter publicly available.

LEGISLATIVE ACTIVITIES

During this reporting period, the OIG provided technical comments to the Office of Management and Budget on the following bills: S. 2178, the Inspector General Recommendation Transparency Act of 2017, and H.R. 4917, the IG Subpoena Authority Act.

Over the course of 2017, the OIG conducted multiple briefings with Congressional staff that detailed problems with OPM's Multi-State Plan Program. This reporting period saw the introduction of bills in both the Senate and House of Representatives that would repeal the program.

In March 2018, the OPM Acting Inspector General joined the Council of the Inspectors General on Integrity and Efficiency's Legislation Committee. The OIG has already provided comments to the Legislation Committee on various bills related to issues such as improper payments and IG testimonial subpoena authority.

We also continue to meet with Congressional offices to educate them on the need to amend the Anti-Kickback Statute so that kickbacks will be illegal in the Federal Employees Health Benefits Program (as they are for all other health care programs financed by Federal taxpayer dollars).

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries:

Indictments and Informations	37
Arrests	28
Convictions	20
Criminal Complaints	1
Subjects Presented for Prosecution	37
■ Federal Venue	36
■ State Venue	1
■ Local Venue	0
Expected Recovery Amount to OPM Programs	\$7,808,415
■ Civil Judgments and Settlements	\$1,159,855
■ Criminal Fines, Penalties, Assessments, and Forfeitures	\$2,992,693
■ Administrative Recoveries	\$3,655,867
Expected Recovery Amount All Programs and Victims	\$77,122,179 ¹

Investigative Administrative Actions:

Investigative Reports Issued	88 ²
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	17
■ Health Care Cases Referred to the OIG for Suspension and Debarment	12
■ NBIB Cases Referred to OPM for Suspension and Debarment	4
Personnel Suspensions and Terminations	3

Administrative Sanctions Activity:

Health Care Debarments and Suspensions Issued	577
Health Care Provider Debarment and Suspension Inquiries	2,296
Health Care Debarments and Suspensions in Effect at End of Reporting Period	35,427

¹This figure represents criminal fines/penalties and civil judgments/settlements 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.

²The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative activity reports.



OIG Hotline Case Activity:

OIG Hotline Cases Opened 1233

Sources of OIG Hotline Cases Opened

- Email 102
- Fax 2
- Letter 122
- Website 750
- Telephone 257

OIG Hotline Cases Reviewed and Closed 1162

- Referred to External Agency or OPM 570
- No Basis Provided for Further Action 40
- No Jurisdiction or OPM violation 356
- Caller seeking Information or Matter Resolved 191
- Converted to a Case 5

OIG Hotline Cases Pending Further Review 71

OIG Case Activity:

	Health Care	Retirement	Revolving Fund	Other/ Internal	Total
Cases Opened	28	14	9	0	51
Investigations	5	3	1	0	9
Complaints	23	11	8	0	42
Inquiries Opened	751	25	14	4	794
Referrals – FEHBP Carriers	532	0	0	0	532
Referrals – All Other Sources	219	25	14	4	262
Cases Closed³	139	39	21	10	209
Investigations	36	17	4	6	77
Complaints	103	22	17	4	148
Inquiries Closed⁴	540	12	14	3	569
Referrals – FEHBP Carriers	317	0	0	0	317
Referrals – All Other Sources	223	12	14	3	252
Cases In-Progress	198	53	30	10	291
Investigations	69	24	5	6	104
Complaints	129	29	25	4	187
Inquiries In-Progress	297	16	2	1	316
Referrals – FEHBP Carriers	212	0	0	0	215
Referrals – All Other Sources	85	16	2	1	104

³Cases closed may have been opened in a previous Semiannual Report period.

⁴Inquiries closed may have been opened in a previous Semiannual Report period.

Appendices

APPENDIX I-A Final Audit Reports Issued With Questioned Costs for Insurance Programs OCTOBER 1, 2017 TO MARCH 31, 2018

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	\$ 22,577,208
B. Reports issued during the reporting period with findings	9	92,856,953
Subtotals (A+B)	13	115,434,161
C. Reports for which a management decision was made during the reporting period:	9	28,409,649
1. Disallowed costs	N/A	28,409,649
2. Costs not disallowed	N/A	0 ⁵
D. Reports for which no management decision has been made by the end of the reporting period	4	87,024,512
E. Reports for which no management decision has been made within 6 months of issuance	2	22,494,512

⁵Represents the net costs, which includes overpayments and underpayments, to insurance carriers. Underpayments are held (not returned to insurance carriers) until overpayments are recovered.



APPENDIX I-B
Final Audit Reports Issued With Questioned Costs
for All Other Audit Entities

OCTOBER 1, 2017 TO MARCH 31, 2018

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$170,266
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	1	170,266
C. Reports for which a management decision was made during the reporting period:	1	170,266
1. Disallowed costs	N/A	170,266
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0



APPENDIX II

Resolution of Questioned Costs in Final Audit Reports for Insurance Programs

OCTOBER 1, 2017 TO MARCH 31, 2018

Subject	Questioned Costs
A. Value of open recommendations at the beginning of the reporting period	\$ 89,130,931
B. Value of new audit recommendations issued during the reporting period	92,856,953
Subtotals (A+B)	181,987,884
C. Amounts recovered during the reporting period	30,226,599
D. Amounts allowed during the reporting period	7,388,560
E. Other adjustments	(369,349) ⁶
Subtotals (C+D+E)	37,245,810
F. Value of open recommendations at the end of the reporting period	\$144,742,074

⁶Additional lost investment income.

APPENDIX III

Final Audit Reports Issued With Recommendations for Better Use of Funds

OCTOBER 1, 2017 TO MARCH 31, 2018

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$108,880,417
B. Reports issued during the reporting period with findings	0	0
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	1	108,880,417



APPENDIX IV
Insurance Audit Reports Issued
OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued	Questioned Costs
IH-01-00-16-044	Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. for Contract Years 2012 through 2014 in Scottsdale, Arizona	October 2, 2017	\$ 1,562,397
1A-10-70-17-019	Premiera BlueCross in Mountlake Terrace, Washington	October 2, 2017	0
1D-9K-00-17-004	Aetna Health of Utah Inc. in Sandy, Utah	December 13, 2017	2,420,230
IC-51-00-16-057	Health Insurance Plan of New York in New York, New York	December 13, 2017	1,579,859
1B-42-00-17-006	Compass Rose Benefits Group in Reston, Virginia	January 16, 2018	3,480,136
1M-0G-00-17-034	Multi-State Plan Program Operations at BlueCross BlueShield of Alabama in Birmingham, Alabama	January 16, 2018	0
1J-0J-00-17-016	Federal Employees Dental and Vision Insurance Program Operations as Administered by Humana Dental for Contract Years 2014 and 2015 in Roswell, Georgia	February 6, 2018	0
1A-99-00-16-021	Global Veterans Affairs Claims for BlueCross and BlueShield Plans in Washington, D.C.	February 28, 2018	58,023,161
1D-SI-00-17-022	BlueShield of California Access+ HMO in San Francisco, California	February 28, 2018	4,908,939
1A-99-00-17-001	Cash Management Activities for a Sample of BlueCross and/or BlueShield Plans in Washington, D.C.	March 14, 2018	6,315,970
1A-99-00-16-062	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	March 15, 2018	6,506,839
1A-10-67-17-021	BlueShield of California in San Francisco, California	March 29, 2018	8,059,422
TOTALS			\$92,856,953



APPENDIX V

Internal Audit Reports Issued

OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued
4A-CF-00-17-033	OPM's Data Submission and Compliance with the Digital Accountability and Transparency Act in Washington, D.C.	November 9, 2017
4A-CF-00-17-028	OPM's FY 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017
4A-CF-00-17-029	OPM's FY 2017 Closing Package Financial Statements in Washington, D.C.	November 16, 2017
4A-OO-00-17-046	Limited Scope Audit of OPM's Purchase Card Transactions in Washington, D.C.	November 27, 2017
4A-CF-00-15-049	OPM's Travel Card Program in Washington, D.C.	January 16, 2018
4A-OO-00-17-035	OPM's Award of a Credit Monitoring and Identity Theft Services Contract to Identity Theft Guard Solutions, LLC in Washington, D.C.	February 28, 2018
4A-CF-00-16-055	OPM's Common Services in Washington, D.C.	March 29, 2018

APPENDIX VI

Combined Federal Campaign Audit Reports Issued

OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued
3A-CF-00-17-024	SoCal CFC for the 2014 and 2015 Campaigns in San Diego, California	October 2, 2017
3A-CF-00-17-023	CFC of Greater SoCal for the 2014 and 2015 Campaigns in Los Angeles, California	October 12, 2017



APPENDIX VII Information Systems Audit Reports Issued OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued
4A-CI-00-17-020	Federal Information Security Modernization Act for FY 2017 in Washington, D.C.	October 27, 2017
1A-10-56-17-008	Information Systems General and Application Controls at BlueCross BlueShield of Arizona in Phoenix, Arizona	December 13, 2017
1C-ML-00-17-027	Information Systems General and Application Controls at AvMed Health Plan in Miami, Florida	December 18, 2017
1B-47-00-17-018	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland	January 16, 2018
4A-MO-00-18-004	Information Technology Security Controls of OPM's CFC System in Washington, D.C.	March 29, 2018

APPENDIX VIII Special Review Reports Issued OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued
L-2018-1	Management Advisory Report: Review of OPM's Non-Public Decision to Prospectively and Retroactively Re-Appportion Annuity Supplements	February 5, 2018
1C-LB-00-18-023	Flash Audit Alert – Obstruction by Health Net of California in Rancho Cordova, California	February 12, 2018
4A-CI-00-18-022	Management Advisory Report OPM's FY 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018

APPENDIX IX Evaluations Reports Issued OCTOBER 1, 2017 TO MARCH 31, 2018

Report Number	Subject	Date Issued
4K-RS-00-17-039	Evaluation of OPM's Retirement Services' Imaging Operations in Washington, D.C.	March 14, 2018



APPENDIX X

Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2018

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-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
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; 7 open recommendations	November 8, 2013



APPENDIX X

Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2018

(Continued)

Report Number	Subject	Date Issued
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-CI-00-14-015	Information Technology Security Controls OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 2 open recommendations	June 6, 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; 15 open recommendations	November 12, 2014
4K-RS-00-14-076	The Review of the OPM's Compliance with the Freedom of Information Act in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 23, 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; 1 open recommendation	April 13, 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-99-00-14-046	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	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; 4 open recommendations	July 29, 2015
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; 1 open recommendation	July 31, 2015



APPENDIX X

Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2018

(Continued)

Report Number	Subject	Date Issued
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; 1 open recommendation	October 14, 2015
4A-CI-00-15-011	Federal Information Security Modernization Act for FY 2015 in Washington, D.C.; 27 total recommendations; 16 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 Chicago, Illinois; 16 total recommendations; 3 open recommendations	November 19, 2015
4K-RS-00-16-024	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
1A-99-00-15-008	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 8 total recommendations; 3 open recommendations	January 21, 2016
4A-CF-00-16-026	OPM's FY 2015 Improper Payments Reporting in Washington, D.C.; 6 total recommendations; 1 open recommendation	May 11, 2016
4A-CI-00-16-037	Second Interim Status Report on OPM's Infrastructure Improvement Project – Major IT Business Case in Washington, D.C.; 2 total recommendations; 2 open recommendations	May 18, 2016
1A-99-00-15-047	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	June 17, 2016
4A-CA-00-15-041	OPM's Office of Procurement Operations' Contract Management Process in Washington, D.C.; 6 total recommendations; 6 open recommendations	July 8, 2016
1C-L4-00-16-013	HMO Health Ohio in Cleveland, Ohio; 2 total recommendations; 2 open recommendations	September 23, 2016
4K-RS-00-16-023	OPM's Retirement Services' Customer Service Function in Washington, D.C.; 3 total recommendations; 2 open recommendations	September 28, 2016
1A-99-00-15-060	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	October 13, 2016



APPENDIX X

Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2018

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.; 4 total recommendations; 4 open recommendations	October 13, 2016
4A-CI-00-16-039	Federal Information Security Modernization Act of FY 2016 in Washington, D.C.; 26 total recommendations; 21 open recommendations	November 9, 2016
1A-10-33-15-009	BlueCross BlueShield of North Carolina in Durham, North Carolina; 6 total recommendations; 5 open recommendations	November 10, 2016
4A-CF-00-16-030	OPM's FY 2016 Consolidated Financial Statements in Washington, D.C.; 22 total recommendations; 18 open recommendations	November 14, 2016
4A-RS-00-16-035	Information Security Controls of OPM's Federal Annuity Claims Expert System; 13 total recommendations; 10 open recommendations	November 21, 2016
4A-CF-00-17-012	OPM's FY 2016 Improper Payments Reporting in Washington, D.C.; 10 total recommendations; 1 open recommendation	May 11, 2017
4A-CI-00-17-014	OPM's Security Assessment and Authorization Methodology in Washington, D.C.; 4 total recommendations; 4 open recommendations	June 20, 2017
1A-99-00-16-043	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 1 open recommendation	June 21, 2017
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York; 15 total recommendations; 1 open recommendation	June 30, 2017
4A-OO-00-16-046	OPM's Purchase Card Program in Washington, D.C.; 12 total recommendations; 12 open recommendations	July 7, 2017
4A-CF-00-17-043	Information Technology Security Controls of OPM's Consolidated Business Information System in Washington, D.C.; 7 total recommendations; 5 open recommendations	September 29, 2017
4A-CF-00-17-044	Information Technology Security Controls of OPM's Federal Financial System in Washington, D.C.; 9 total recommendations; 9 open recommendations	September 29, 2017
4A-CI-00-17-030	Information Technology Security Controls of OPM's SharePoint Implementation in Washington, D.C.; 8 total recommendations; 8 open recommendations	September 29, 2017



APPENDIX XI

Most Recent Peer Review Results

AS OF MARCH 31, 2018

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 ⁷
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
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, Corporation for National and Community Service)</i>	December 2, 2016	Compliant ⁸
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the National Science Foundation <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	December 14, 2017	Compliant

⁷A 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.

⁸A rating of **Compliant** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the 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 XII Investigative Recoveries

OCTOBER 1, 2017 TO MARCH 31, 2018

Statistics Type	OPM Organization	Total Recovery Amount	OPM Recovery Net
Administrative		\$3,655,867	\$3,655,867
	Healthcare and Insurance	\$2,827,034	\$2,827,034
	Collection of Improper Payments	\$2,827,034	\$2,827,034
	National Background Investigations Bureau	\$199,444	\$199,444
	Contract Off-Sets	\$199,444	\$199,444
	Retirement Services	\$629,390	\$629,390
	Administrative Debt Recovery	\$184,845	\$184,845
	Bank Reclamation	\$74,143	\$74,143
	Collection of Improper Payments	\$303,946	\$303,946
	Voluntary Payment Agreement	\$66,455	\$66,455
Civil		\$18,276,603	\$1,159,855
	Healthcare and Insurance	\$18,276,603	\$1,159,855
	Judgments/Settlements	\$18,276,603	\$1,159,855
Criminal		\$55,189,708	\$2,992,693
	Healthcare and Insurance	\$53,155,704	\$2,137,245
	Court Assessment/Fees	\$11,675	\$0
	Criminal Fine	\$11,975	\$0
	Criminal Judgment/Restitution	\$53,132,054	\$2,137,245
	Contract Fraud	\$829,661	\$0
	Asset Forfeiture	\$443,996	\$0
	Court Assessment/Fees	\$100	\$0
	Criminal Judgment/Restitution	\$385,565	\$0
	Retirement Services	\$1,204,343	\$855,449
	Court Assessment/Fees	\$700	\$0
	Criminal Judgment/Restitution	\$1,203,643	\$855,449
Grand Total		\$77,122,179	\$7,808,415

Index of Reporting Requirements

(INSPECTOR GENERAL ACT OF 1978, AS AMENDED)

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OIG Hotline

Report Fraud, Waste or Abuse to the Inspector General



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