APRIL 1, 2018 – SEPTEMBER 30, 2018

Semiannual Report to Congress

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

OFFICE OF THE INSPECTOR GENERAL

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Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds	$16,506,487
Management Commitments to Recover Funds	$25,140,891
Recoveries Through Investigative Actions	$17,220,493

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	20
Evaluation Reports Issued	0
Management Advisories Issued	1
Investigations and Complaints Closed	137
Indictments and Informations	51
Arrests	37
Convictions	34
Hotline Contacts and Complaints Received	1,562
Hotline Contacts and Complaints Closed	616
FEHBP Provider Debarments and Suspensions	337
FEHBP Provider Debarment and Suspension Inquiries	2,311

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Message from the Acting Inspector General

I would like to extend a warm welcome to Margaret M. Weichert, who recently joined the U.S. Office of Personnel Management (OPM) as the new Acting Director. Our office looks forward to working with her to continue to meet the needs of the Federal workforce.

This year, we celebrated the anniversaries of three pieces of legislation of enormous significance to the OPM Office of the Inspector General (OIG), the Federal Inspector General community, and the entire Federal Government. First, October 12th marked the 40th anniversary of the Inspector General Act of 1978, which created the position of Federal Inspector General at 12 agencies. On October 18th, we recognized the 30th anniversary of the Inspector General Act Amendments of 1988, which spread the Inspector General model Government-wide, establishing new Inspectors General at 30 additional agencies. Finally, October 14th was the 10th anniversary of the Inspector General Reform Act of 2008, which established the Council of the Inspectors General on Integrity and Efficiency (CIGIE) to promote professionalism and effectiveness among the 73 current Inspectors General and address oversight issues that transcend individual agencies.

CIGIE has coordinated a series of events to commemorate these anniversaries. In July, CIGIE organized a conference at the U.S. Capitol Visitor Center that explored the role of the Inspectors General, their collective achievements, and their future. The event featured a distinguished array of panelists from the Executive and Legislative branches, academia, the press, and non-Government watchdog organizations. These included current and former Inspectors General and agency heads, as well as two sitting senators, Ron Johnson of Wisconsin and Heidi Heitkamp of North Dakota. Our new Acting Director, Ms. Weichert, also spoke in her capacity as the Deputy Director for Management at the Office of Management and Budget.

The anniversary of the Inspector General Act Amendments of 1988 is of particular significance to our office, as the Act that established the OPM OIG as a statutory entity. Accordingly, I would like to take the opportunity to reflect on some of our office's achievements over the past three decades. I am proud to announce that we have issued over 2,100 audit and evaluation reports, recommending the recovery of almost $2.3 billion to OPM. We have also secured close to 900 criminal convictions, and our investigative staff has recovered over $1 billion on behalf of OPM programs. We have also debarred or suspended over 43,000 health care providers from participation in the Federal Employees Health Benefits Program, ensuring that only those who meet professional standards are caring for Federal employees, annuitants, and their families.

(continued on next page)

Finally, I would like to thank all the individuals who have served with the OPM OIG during the past thirty years. Since joining the OPM OIG in 1999, I have been privileged to work with an eminently talented and professional multi-disciplinary staff including auditors, investigators, evaluators, analysts, human resources specialists, contracting officers, attorneys, and more. The past three decades' achievements would not be possible without their dedicated service.

Norbert E. Vint

Acting Inspector General

Mission Statement

To provide independent and objective oversight of OPM 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.

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Field Offices

Audit Activities

Health Insurance Carrier Audits

OPM contracts with both private sector health plans and health plans operated or sponsored by Federal employee organizations to provide health insurance through the Federal Employees Health Benefits Program (FEHBP), as well as through the marketplaces under the Multi-State Plan Program created by the Patient Protection and Affordable Care Act (Affordable Care Act). The Office of Audits is responsible for auditing the activities of these health plans to ensure that they meet their contractual obligations with OPM. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the health insurance carrier, the time elapsed since the last audit, and our previous audit results.

The OIG's insurance audit universe encompasses approximately 275 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites fluctuates due to the addition, non-renewal, and merger of participating health insurance carriers. The combined premium payments for these health insurance programs total 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). They are responsible for paying claims and administrative costs incurred, and are paid an amount commensurate with the number of subscribing FEHBP members and the premiums paid by those members. Consequently, community-rated carriers suffer the loss if the costs incurred by the plan exceed the amount of premiums received.

Experience-rated carriers are mostly fee-for-service plans, the largest being the Blue Cross Blue Shield (BCBS) health plans, but also include experience-rated HMOs. These carriers are reimbursed for actual claims paid and administrative expenses incurred, and paid a service charge that is determined in negotiation with OPM.

During the current reporting period, we issued eight final audit reports on health plans participating in the FEHBP, which contained recommendations for the return of $16.5 million to the OPM-administered trust fund.

COMMUNITY-RATED CARRIERS

The community-rated carrier audit universe includes 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 law and regulation.

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. This is to ensure that the Government receives the most favorable rates for a customer of similar size.

SSSG audits of traditional community-rated carriers focus on ensuring that:

- The health plans selected appropriate SSSGs;
- The FEHBP rates are equivalent to those charged to the SSSGs; and
- The loadings applicable to the FEHBP rates are appropriate and reasonable.

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

Medical Loss Ratio Audits

In April 2012, OPM issued a final rule establishing an FEHBP-specific medical loss ratio (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 requires the carriers to submit an FEHBP-specific MLR. The FEHBP-specific MLR requires 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. 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.

The report summaries below highlight notable audit findings for community-rated FEHBP carriers audited during this reporting period.

HealthPlus of Michigan
Flint, Michigan
Report No. 1C-X5-00-17-032
April 24, 2018

HealthPlus of Michigan has participated in the FEHBP since 1995, and provides health benefits to FEHBP members in the eastern Michigan area. However, effective January 1, 2017, the Plan merged with Health Alliance Plan and ceased participation in the FEHBP. The audit covered contract years 2013 through 2015. During this period, the FEHBP paid HealthPlus approximately $56.7 million in premiums.

HealthPlus used inaccurate claim amounts in 2013, 2014, and 2015 MLR calculations.

Our audit identified $527,027 in overstated MLR credits for these years. We also found the following:

- HealthPlus used an unsupported premium amount and an inaccurate adjusted incurred claims amount in its 2013 MLR calculation. These errors resulted in an overstatement of HealthPlus' 2013 MLR credit totaling $188,957;
- HealthPlus used an inaccurate adjusted incurred claims amount in its 2014 MLR calculation. These errors resulted in an overstatement of HealthPlus' 2014 MLR credit totaling $315,052;
- HealthPlus used an inaccurate adjusted incurred claims amount in its 2015 MLR calculation. We also identified errors in the Quality Health Improvement and Health Insurance Provider Fee expense allocations. These errors resulted in an overstatement of HealthPlus' 2015 MLR credit totaling $23,018;
- HealthPlus did not have sufficient controls over its FEHBP MLR process, which resulted in its inability to adequately support FEHBP-specific MLRs filed with OPM; and
- HealthPlus did not maintain a required Fraud, Waste, and Abuse (FWA) Manual or provide all FWA potential case notifications to the OPM OIG.

HealthPlus agreed with all of our audit findings and the overstated credit amounts were adjusted by OPM. Since HealthPlus ceased its participation in the FEHBP, we did not offer recommendations on the remaining issues.

Health Alliance Plan
Southfield, Michigan
Report No. 1C-52-00-17-031
May 10, 2018

Health Alliance Plan has participated in the FEHBP since 1962, and provides health benefits to FEHBP members in the Detroit and other parts of southeastern Michigan. The audit covered contract years 2013 and 2014. During this period, the FEHBP paid the Health Alliance approximately $236.5 million in premiums.

Our audit identified $1,215,409 in overstated MLR credits for these contract years. We also found the following:

- Health Alliance used inconsistent membership timeframes to calculate the quality health improvement and tax allocation expenses in 2013.
- Health Alliance also included claims for unsupported disabled and ineligible overage dependents in their MLR calculations.

Health Alliance agreed with most of our audit findings and the overstated credit amount was adjusted by OPM, thus closing two recommendations. Corrective actions were implemented to address the three remaining recommendations, thus closing the audit.

EXPERIENCE-RATED CARRIERS

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.

Blue Cross Blue Shield Service Benefit Plan Audits

The BCBS Association, on behalf of 64 participating plans offered by 38 BCBS companies, enters into a Government-wide Service Benefit Plan contract 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. Over 60 percent of all FEHBP subscribers are enrolled in BCBS plans.

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management of 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 which 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 keeping an accounting for all FEP funds.

Below is a summary of a BCBS audit that is representative of the work we do.

BlueCross BlueShield of North Carolina

Durham, North Carolina
Report Number 1A-10-33-18-001
August 28, 2018

Our audit of the FEHBP operations at BCBS of North Carolina (BCBS-NC) covered health benefit payments and credits as well as administrative expense charges. We also reviewed the Plan's cash management and fraud and abuse program activities and practices.

Auditors questioned over $4 million in benefits charges, administrative expenses, cash management activities, and lost investment income.

We questioned $4,231,513 in health benefit charges, administrative expenses, cash management activities, and lost investment income. The BCBS Association and BCBS-NC agreed with $4,134,031 and disagreed with $97,482 of these questioned amounts. Our findings included the following:

- We questioned $2,524,636 in administrative expenses and applicable lost investment income.
- We determined that BCBS-NC held excess FEHBP funds of $1,593,740 in the dedicated FEP investment account.

- We questioned $113,137 where BCBS-NC had not recovered and/or returned funds to the FEHBP for claim overpayments.
- We also found that BCBS-NC is in compliance with the OPM's reporting requirements for fraud and abuse cases.

Global Audits

Global audits of BCBS plans are cross-cutting reviews of specific issues we have determined to be likely to cause improper payments. These audits cover all 64 BCBS plans offered by the 38 participating BCBS companies.

Below is a summary of the global audit we conducted during the reporting period.

FEHBP Global Operations Claims-to-Enrollment Match for BCBS Plans

Washington, D.C.
Report Number 1A-99-00-17-048
August 28, 2018

We completed a limited-scope performance audit of the FEHBP operations at all BCBS plans, covering claims paid between October 1, 2014 and May 31, 2017. We identified and audited claims from this period for services incurred:

- when no enrollee enrollment record existed;
- during gaps of coverage; or
- after termination of enrollee coverage.

Auditors questioned over $7.3 million in health benefits charges for ineligible members.

For many years, we have had serious concerns related to the efforts of BCBS plans and the BCBS Association to implement corrective actions to prevent enrollment claim payment errors. Our audits (performed since 2009) have routinely shown that retroactive adjustments are the primary reason for enrollment claim payment errors. Since we began these audits, we have identified a cumulative $38 million in claim overpayments related to enrollment errors.

Although the BCBS Association has taken several steps to reduce enrollment errors, the results of this audit continue to indicate that these corrective actions have not had a substantial impact in reducing the amount of enrollment payment errors. Our audit determined that, in a 32-month period, BCBS plans paid $12,357,989 in error for ineligible members that should not be participating in the FEHBP. Since the BCBS Association initiated recovery for $5,010,634 of the claim overpayments prior to the start of this audit, this amount is not included in the questioned costs.

This report questioned the remaining $7,347,355 in health benefit charges.

Employee Organization Plans

Employee organization plans fall into the category of experience-rated plans. These plans either operate or sponsor participating Federal health benefits plans. 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 of the employee organizations that participate in the FEHBP include the American Postal Workers Union; Association of Retirees of the Panama Canal Area; Government Employees Health Association, Inc. (GEHA); 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 summarized below.

Government Employees Health Association, Inc.

Lee's Summit, Michigan
Report Number 1B-31-00-17-041
May 10, 2018

Our audit of the FEHBP operations at GEHA covered health benefit credits, such as refunds and pharmacy drug rebates, cash management, and GEHA's fraud and abuse program.

We found that GEHA held an excess working capital deposit of $3,660,811 in its dedicated FEHBP investment account and recommended that these funds be returned to the FEHBP trust fund.

GEHA held an excess working capital deposit of over $3.6 million and auditors recommended it be returned to the FEHBP trust fund.

We also determined that GEHA is not in compliance with OPM's communication and reporting requirements for fraud and abuse cases. We identified several areas of non-compliance regarding GEHA's fraud and abuse program policies and procedures and its 2015 and 2016 annual fraud, waste, and abuse reports.

The audit disclosed no findings pertaining to health benefit credits. Overall, we concluded that GEHA timely returned health benefit refunds and recoveries, including pharmacy drug rebates, to the FEHBP.

Experience-Rated HMO Plans

Health maintenance organization (HMO) plans fall into one of two categories: community-rated or experience-rated. As we previously explained in "Audit Activities" on page 1 of this report, the key difference between the categories stems from how premium rates are calculated. (Experience-rating is retrospective while community-rating is prospective.) An experience-rated HMO plan also gives members the option of using a designated HMO network of providers or using out-of-network providers, whereas a community-rated HMO plan provides care to members through a designated HMO network of providers in particular geographic or service areas. With an experience-rated HMO plan, if a member chooses an out-of-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued one experience-rated comprehensive medical plan audit report during this reporting period, which is summarized below.

Hawaii Medical Service Association

Honolulu, Hawaii
Report Number 1D-87-00-17-038
June 11, 2018

Our audit of Hawaii Medical Service Association (HMSA) covered health benefit payments and credits, such as refunds and pharmacy drug rebates, and administrative expenses. We also reviewed HMSA's cash management activities and practices, as well as HMSA's fraud and abuse program.

We questioned $1,208,306 in cash management activities and lost investment income. We also identified a procedural finding regarding HMSA's fraud and abuse program. HMSA agreed with all of the questioned amounts and the procedural finding for its fraud and abuse program.

Auditors question $1.2 million in cash management activities and lost investment income.

Multi-State Plan Program

The Multi-State Plan (MSP) Program was established by Section 1334 of the Affordable Care Act. This provision directs OPM to

contract with private health insurers (called 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. In 2018, however, there was only one issuer that participated in the program (BCBS of Arkansas). Our audits of the MSP Program assess the issuer's compliance with the provisions of its contract with OPM, as well as with applicable Federal law and regulation.

We did not issue any final reports for MSP audits during this reporting period.

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems support background investigations for Federal employees, the processing of retirement claims, and multiple Government-wide human resources services. Private health insurance carriers participating in the FEHPB rely upon information systems to administer health benefits to millions of current and former Federal employees and their dependents. The ever-increasing frequency and sophistication of cyber-attacks on both the private and public sector makes the implementation and maintenance of mature cybersecurity programs a critical need for OPM and its contractors. Our information technology (IT) audits identify potential weaknesses in the auditee's cybersecurity posture and provide tangible strategies to rectify and/or mitigate those weaknesses. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the health insurance carrier, the sensitivity of the information in the system, the time elapsed since the last audit, and our previous audit results.

Our audit universe encompasses all 54 OPM-owned information systems as well as the 90 information systems used by private sector entities that contract with OPM to process Federal data. We issued six IT system audit reports during the reporting period and several of the more notable ones are summarized below.

OPM's Fiscal Year (FY) 2018 IT Modernization Expenditure Plan

Washington, D.C.
Report Number 4A-CI-00-18-044
June 20, 2018

The Consolidated Appropriations Act of 2018 made available $21 million to OPM "for information technology infrastructure modernization and Trust Fund Federal Financial System migration or modernization." The Act further stated that those sums may not be obligated until the agency submitted a spending plan that is "reviewed and commented upon" by the OIG.[1]

Based on our review of the Office of the Chief Information Officer's (OCIO) FY 2018 IT Modernization Expenditure Plan, it appears that OPM is generally continuing in the right direction when it comes to modernizing OPM's IT environment. This encouraging development notwithstanding, we had several concerns with the FY 2018 Plan, including:

OPM's modernization expenditure plans are moving in the right direction, but the funds need to be directed towards infrastructure improvements.

- As with the FY 2017 spending plan, the FY 2018 Plan does not meet the explicit requirements of the Appropriations Act. To be fair, OPM has not had enough time to establish the baseline requirements that OCIO officials told us would be required to develop adequate planning and budgeting processes. Despite OPM's long history of failed commitments, changing priorities, and turnover in critical leadership positions, we are cautiously optimistic that this effort may be successful, but we will very closely monitor and report on the agency's progress.

[1] This is very similar to language in the FY 2017 Consolidated Appropriations Act. Our report on OPM's FY 2017 IT Modernization Expenditure Plan (Report No. 4A-CI-00-18-022, issued February 15, 2018) is available at: https://www.opm.gov/our-inspector-general/management-advisory-reports/management-advisory-report-us-office-of-personnel-management%E2%80%99s-fiscal-year-2017-it-modernization-expenditure-plan.pdf.

- The allocation of the $21 million appropriated in the FY 2018 Consolidated Appropriations Act is not primarily based on an objective analysis of IT modernization needs. It appears that some of the funds are targeted toward satisfying deferred business process automation needs based on considerations related to the President's Management Agenda, and not enough is being allocated for true infrastructure improvements.

Information Systems Technology Security Controls of OPM's Health Claims Data Warehouse

Washington, D.C.
Report Number 4A-PP-00-18-011
June 25, 2018

The Health Claims Data Warehouse (HCDW) is one of OPM's major IT systems. Pursuant to its administration of the FEHBP, OPM uses the HCDW to receive, store, and analyze health insurance claims from experience-rated insurance carriers, and to review data from HMOs. Our audit of the IT security controls of the HCDW determined that:

- The HCDW Security Assessment and Authorization (Authorization) was in place through May 2018. At the time of this audit, work on a new Authorization was underway and a one-year Authorization was granted through May 2019.
- The HCDW System Security Plan follows the OCIO template, but did not adequately reflect the current state of the system.
- A full security controls assessment was completed for the HCDW in January 2015, however many of the assessed controls were incorrectly labeled in relation to the system's "high" categorization.
- The HCDW has not been subject to routine continuous monitoring testing.
- OPM developed and tested a contingency plan for the HCDW, however the plan has not been updated to account for major changes to the system.
- The HCDW Plan of Action and Milestones documentation does not contain all OPM required fields and several of the weaknesses have not been remediated timely.
- We evaluated a subset of the system controls outlined in National Institute for Standards and Technology (NIST) Special Publication (SP) 800-53, Revision 4. We determined most of the security controls tested appear to be in compliance, however we did note several areas for improvement.

Information Systems Technology Security Controls of OPM's USA Staffing System

Washington, D.C.
Report Number 4A-HR-00-18-013
May 10, 2018

The USA Staffing System is another one of OPM's major IT systems. It is used by human resources personnel to create and manage position vacancy announcements, application assessments, and job questionnaires; by job applicants to apply for open jobs; and by hiring managers to select candidates. Our audit of the IT security controls of the USA Staffing System determined that:

- The USA Staffing Authorization was updated in September 2017, and an Authorization to Operate was granted for up to three years.
- The security categorization of the USA Staffing System is consistent with Federal Information Processing Standards 199 and NIST Special Publication (SP) 800-60, and we agree with the categorization of "moderate."

- The system security plan for the USA Staffing System follows OPM policy, but the system inventory includes instances of unsupported software.
- An independent assessor conducted security controls testing and assessed identified risks for the USA Staffing System.
- The USA Staffing System has been subject to routine testing as part of OPM's continuous monitoring program.
- OPM developed and tested a contingency plan for the USA Staffing System that is generally in compliance with NIST SP 800-34, Revision 1, and internal guidance.
- The USA Staffing System Plan of Action and Milestones documentation from the most recent Authorization does not include all identified weaknesses.
- Most of the security controls tested appear to be in compliance with NIST SP 800-53, Revision 4; however, we did note two areas for improvement.

Information Systems General and Application Controls at Blue Cross Blue Shield of Massachusetts

Boston, Massachusetts
Report Number 1A-10-11-17-052
August 23, 2018

BCBS-MA's IT security controls are generally compliant, but several areas still need improvements.

Our audit of the IT security controls of Blue Cross Blue Shield of Massachusetts (BCBS-MA) determined that:

- BCBS-MA has established an adequate security management program.
- BCBS-MA has adequate physical access controls over its facilities and data centers.
- BCBS-MA has not documented and approved a formal configuration management policy. Also, BCBS-MA has not documented security configuration standards for all of the operating platforms in its network environment.
- BCBS-MA has documented contingency plans that are tested on a routine basis.
- BCBS-MA has implemented many controls over its claims adjudication process to ensure that FEHBP claims are processed accurately.

Information Systems General and Application Controls at BCBS of Nebraska

Omaha, Nebraska
Report Number 1A-10-53-17-042
April 17, 2018

Our audit of the IT security controls of Blue Cross Blue Shield of Nebraska (BCBS-NE) determined that:

- BCBS-NE has established an adequate security management program.
- BCBS-NE has adequate physical access controls for its facilities and data centers. Furthermore, BCBS-NE has adequate logical access controls protecting sensitive data in its network environment.
- BCBS-NE does not conduct routine vulnerability scanning of its web applications. Furthermore, BCBS-NE does not have a formal process to ensure that vulnerabilities identified from vulnerability scanning are remediated in a timely manner.
- BCBS-NE has implemented adequate controls in its claims adjudication process to ensure that FEHBP claims are processed accurately.

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM operations and their corresponding internal controls. They are also responsible for conducting or overseeing certain statutorily required audits, including the annual audit of OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the program, the time elapsed since the last audit, and our previous audit results.

We completed two internal performance audits during the reporting period, which are discussed below.

OPM's Personnel Security Adjudication Process

Washington, D.C.
Report No. 4A-CF-00-17-050
August 20, 2018

Our auditors completed a performance audit of OPM's personnel security adjudications process. The Personnel Security office is responsible for addressing all of the security-related requirements of OPM's personnel, both Federal employees and contractors. They also receive work delegated by the Director of OPM for such things as obtaining higher-level clearances for senior level OPM employees. The Personnel Security office's goal is to provide timely processing of background investigation applications for new applicants and contractors through all personnel security-related areas.

OPM's Personnel Security office properly adjudicated background investigation cases.

The objectives of our audit were to determine if the OPM Facilities, Security and Emergency Management (FSEM) Personnel Security office is adjudicating background investigations cases properly and employing a financial process involving inter-agency agreements that is effective.

Our audit found that the Personnel Security office properly adjudicated background investigations cases and that their financial process is effective; however, we identified one area for improvement that, when addressed, could have a positive impact on OPM's Personal Identity Verification process. Specifically, we made a general observation that FSEM's Security Services office's standard operating procedures were not updated, approved and disseminated timely.

In addition, OPM needs to strengthen controls over its personnel security adjudications process in the following three areas:

- Documentation and maintenance of training records for Adjudicators and Security Assistants.
- Destruction of case files in accordance with the 120-day retention policy.
- Maintenance of case files.

Fiscal Year 2017 Improper Payments Reporting

Washington, D.C.
Report Number 4A-CF-00-18-012
May 10, 2018

The OIG annually audits OPM's reporting of improper payments to assess compliance with the Improper Payments Information Act of 2002 (IPIA), as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments

Elimination and Recovery Improvement Act of 2012 (IPERIA), as well as implementing Office of Management and Budget (OMB) guidance. Compliance with IPERA requires that agencies do the following:

1. Publish an Agency Financial Report (AFR) or Performance and Accountability Report (PAR) for the most recent fiscal year and post that report and any accompanying materials required by OMB on the agency website;
2. Conduct a program specific risk assessment for each program or activity that conforms with Section 3321 of Title 31 United States Code (if required);
3. Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment (if required);
4. Publish programmatic corrective action plans in the AFR or PAR (if required);
5. Publish and meet annual reduction targets for each program assessed to be at risk and estimated for improper payments (if required and applicable); and
6. Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR or PAR.

Our audit found that OPM complied with IPERA's six requirements for FY 2017. We further determined that OPM complied with additional reporting requirements imposed by IPERIA, which include use of the Do Not Pay portal and obtaining approval for both the improper payments rates and reduction targets. In addition, we identified two opportunities for improvement that could have a positive impact on OPM's improper payments reporting. Specifically, we observed that:

- OPM included FY 2018 reduction targets in the data call located on the www.paymentaccuracy.gov website. However, FY 2018 reduction targets were not included in OPM's FY 2017 AFR.
- Since FY 2012, Retirement Services' improper payments rate has remained between 0.36 percent and 0.38 percent, staying within plus or minus 0.1 percentage points of the reduction target set in the previous year's AFR. While this complies with IPERA's requirement that agencies publish and meet annual reduction targets, it does not meet the spirit of IPIA, which is to reduce improper payments.

OPM complied with IPERA's reporting requirements but not its intent, which is to reduce improper payments.

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 as authorized by the Affordable Care Act. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the program, the time elapsed since the last audit, and our previous audit results.

EmblemHealth Dental

New York, New York
Report Number 1J-0L-00-17-051
September 21, 2018

EmblemHealth needs to strengthen its procedures and controls.

We conducted a performance audit of EmblemHealth Dental's annual accounting statements, claims processing, fraud and abuse program, performance guarantees, and premium rate proposals as they relate to FEDVIP operations for contract years 2014 through 2016. The objective was to determine whether costs charged to FEDVIP and services provided to members were in accordance with EmblemHealth Dental's contract with OPM and applicable Federal law and regulation.

We determined that EmblemHealth Dental needs to strengthen its procedures and controls, having made the following findings:

- EmblemHealth Dental failed to submit its 2016 Annual Accounting Statements (AAS), understated its premiums on the 2014 AAS, and inappropriately categorized two line items as expenses in its 2014 through 2016 AASs.
- EmblemHealth Dental paid $10,281 in claims to two debarred providers in 2015 and 2016.
- EmblemHealth Dental failed to track and meet numerous performance standards that it guaranteed for 2014 through 2016.
- EmblemHealth Dental did not support several pricing assumptions used in its 2014 rate proposal.

Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc.

St. Louis, Missouri
Report Number 1H-06-00-17-026
August 16, 2018

We completed a performance audit of the Compass Rose Health Plan's pharmacy benefits operations as administered by Express Scripts, Inc. Our audit included reviews of administrative fees, claim payments, fraud and abuse, performance guarantees, and pharmacy rebates related to the FEHBP for contract years 2012 through 2015.

Compass Rose paid 161 pharmacy claims for 14 ineligible dependents, totaling $14,226.

We determined that Compass Rose Benefits Group (Compass Rose), as underwriter and administer of the Compass Rose Health Plan, and Express Scripts need to strengthen procedures and controls, having made the following findings:

- Express Scripts incorrectly under-billed Compass Rose for specialty pharmacy claim administrative fees.
- Express Scripts initially overcharged Compass Rose $85,854 for brand-name mail-order pharmacy claims paid between July 31, 2014, and December 31, 2014.
- Compass Rose paid 161 pharmacy claims totaling $14,226 for 14 dependents that were ineligible for coverage when the prescription was filled.
- Compass Rose did not provide Express Scripts with the appropriate provider listing to prevent payments to debarred or suspended providers.
- Compass Rose did not report suspected fraud cases received from Express Scripts to the OPM OIG.
- Compass Rose failed to notify Express Scripts of a $6,250 performance guarantee penalty for contract year 2013.

In addition, we identified two opportunities for program improvements related to mail order dispensing fees/reduced copay and maintaining documentation to support copay overrides.

OPM's Oversight of the Rate Monitoring and Procurement Process of the Federal Long Term Care Insurance Program

Washington, D.C.
Report Number 4A-HI-00-17-025
April 5, 2018

The FLTCIP was established in 2000 by the Long Term Care Security Act. The Act directed OPM to develop and administer a long-term care insurance program for Federal employees and annuitants, current and retired members of the uniformed services, and their qualified relatives.

In December 2001, OPM awarded a seven-year contract to Long Term Care Partners (LTCP) to offer long-term care insurance coverage to eligible participants. A new contract was awarded to John Hancock Life and Health Insurance Company (John Hancock) upon the expiration of the original contract. On October 1, 2009, John Hancock became the sole insurer and LTCP became a wholly owned subsidiary of John Hancock. LTCP, with OPM oversight, is responsible for all administrative functions of the program, including marketing and enrollment, underwriting, policy issuance, premium billing and collection, and claims administration.

In April 2016, OPM again awarded the long-term care insurance contract to John Hancock. During the procurement process for this contract, John Hancock was the only

provider to submit a bid. OPM's current contract with John Hancock is set to expire on April 30, 2023. It is a fixed-price contract with prospective price redetermination and the contract is for a base period of seven years.

OPM effectively monitored the FLTCIP procurement process and premium rates.

OPM's Federal Employee Insurance Operations, Individual Benefits and Life Group has overall responsibility for administering the FLTCIP, including the publication of program regulations and agency guidelines.

The main objectives of the audit were to determine whether OPM administered the FLTCIP procurement processes for the 2016 contract re-bid in accordance with the applicable Federal regulations. We also reviewed the extent and involvement of OPM in the FLTCIP rate setting process to determine if OPM had any opportunities to mitigate price increases over the term of the 2009 contract.

While our review found that OPM complied with applicable Federal regulations during the 2016 FLTCIP procurement process and effectively monitored the FLTCIP premium rates during program years 2009 through 2016, we did find a lack of contingency planning on OPM's part. Due to the lack of competition during the prior FLTCIP contract award and the rapidly changing environment of the long-term care insurance industry, we recommended that OPM develop and implement a formal contingency plan well in advance of the next FLTCIP procurement action. The plan should take into consideration the risks in the long-term care insurance market that adversely affect the continuance and feasibility of the program.

Enforcement Activities

Investigative Activities

OPM-administered trust funds, from which benefits are paid under the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI, amount to over $1 trillion. These programs cover over eight million current and retired Federal civilian employees and eligible family members, and disburse over $140 billion annually. The Office of Investigations conducts criminal, civil, and administrative investigations of fraud, waste, abuse, and mismanagement related to OPM programs and operations. We actively coordinate with the U.S. Department of Justice (DOJ) and other Federal, State, and local law enforcement authorities. Our investigations often lead to criminal convictions, civil and criminal recoveries, and administrative actions, including debarments from participation in Federal programs.

The Office of Investigations achieves the greatest impact by assessing OPM programs and operations and identifying the program impact based on data analytics to maximize investigative resources and set priorities. As a result, our current priorities include protecting Federal employees and their dependents from patient and financial harm caused by improper payments, opioid addiction, prescription drug abuse, matters involving national security, and enhancing program integrity by identifying and reporting program deficiencies to internal and external stakeholders.

During the reporting period, our office opened 494 cases and closed 137. Our investigations led to 37 arrests, 51 indictments and informations, 34 convictions and $17,220,493 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 criminal, civil, and administrative recoveries and fines of $811,566,617, which are returned to the General Fund of the U.S. Department of the Treasury. For a statistical summary of our office's investigative activity, refer to the tables on pages "Statistical Summary of Enforcement Activities" on page 33-34. Activities related to our investigative priorities are discussed in more depth in the following sections.

Investigative Priority: Opioid and Drug Abuse Within the FEHBP

In an October 2017 memorandum, "Combatting the National Drug and Opioid Crisis,"[2] the President described the opioid crisis as a public health emergency[3] and directed a multi-agency response to combat the drug demand and

[2] Available at: https://www.whitehouse.gov/presidential-actions/presidential-memorandum-heads-executive-departments-agencies/

[3] The then-Acting Secretary of the U.S. Department of Health and Human Services, Eric D. Hargan, officially declared the opioid crisis to be a nationwide public health emergency on October 26, 2017.

opioid problem afflicting our nation. Consistent with this directive, addressing the opioid crisis has been established as a top priority for the OIG's Office of Investigations.

Over the past several years, we have increasingly encountered the impact of the crisis directly and indirectly in the course of providing oversight of the FEHBP. The program has felt the impact of the crisis through increases in the number of beneficiaries who abuse prescription opioids, cases of physician pill mills, and inappropriate prescriptions of the narcotic fentanyl. We have also seen a significant increase in fraudulent schemes related to unnecessary urine drug testing, and fraud and patient harm within the sober home and substance abuse treatment arenas—all problems which may be attributed in part to a growing opioid epidemic.

In 2017, our office joined a DOJ task force dedicated solely to prosecuting opioid-related health care fraud, including pill mill schemes and pharmacies that unlawfully divert or dispense prescription opioids for illegitimate purposes.

We have also devoted significant resources to assessing program impacts, tracking costs, analyzing trends, and performing criminal investigations in relation to the consequences of the opioid crisis.

***Drug diversion** is the practice of transferring legally prescribed medications from the individual for whom it was prescribed to another person for an illicit use.*

*A **pill mill** is an operation in which a health care provider, facility, or pharmacy prescribes and/or dispenses drugs without a legitimate medical purpose.*

***Doctor or pharmacy shopping** is the practice of visiting multiple physicians or pharmacies to obtain multiple prescriptions for otherwise legal drugs.*

*A **sober home** is in the business of providing a safe and drug-free residence for individuals suffering from drug and alcohol addiction.*

Below are some statistics that describe the extent of the problem in the FEHBP. (Please note that the FEHBP operates on a calendar year, and so figures for 2018 are not currently available.)

- In 2017, gross opioid prescription costs for the top five FEHBP experience-rated carriers were over $152 million.[4]

In 2017, the 5 largest FEHBP experience-rated carriers paid over $152 million for opioid prescriptions.

- Between January 2016 and September 2018, we received 344 reported cases of doctor shopping from FEHBP carriers.
- During 2016 and 2017 alone, the largest FEHBP carrier (covering over 60 percent of all enrollees) identified 22,898 FEHBP beneficiaries potentially abusing prescription opioids. The same carrier reported a greater than 300 percent increase in this number from 2012 to 2017.
- During that same time period (2016-2017), the same FEHBP carrier reported that the number of claims for prescriptions for drugs used to treat opioid-related overdoses (Narcan, Nalaxone, and Evzio) have increased by approximately 50 percent.
- Ancillary opioid-related costs (*e.g.*, treatment of substance abuse and drug testing) have risen sharply at a rate of over 283 percent from 2013 to 2016 according to the same FEHBP carrier.

[4] The carriers included in this figure are: BCBS Association, Government Employees Health Association (GEHA), Mail Handlers Benefit Plan (MHBP), Rural Carrier Benefit Plan (RCBP), and National Association of Letter Carriers (NALC).

- In 2017, among four of the largest FEHBP plans sponsored by employee organizations,[5] the percentage of beneficiaries utilizing opioid prescriptions ranged between 17.8 and 24.3 percent—totaling approximately 232,000 beneficiaries.
- In Florida alone, between January 2016 and September 2018, we received 140 fraud referrals related to sober homes, drug testing labs, rural hospitals used for pass through drug test billing, and substance abuse and behavioral health treatment facilities.

These statistics demonstrate the broad financial and human impact of the opioid crisis on the FEHBP, which goes far beyond the simple over-prescription of certain drugs.

The following cases represent some of our investigative activity during the reporting period relating to the opioid epidemic.

Florida Sober Home Owner Indicted for Health Care Fraud

On June 22, 2018, the owner of a Florida sober home, along with co-conspirators, was charged with conspiracy to commit health care fraud and wire fraud. The owner was allegedly paying physicians to utilize their names as attending providers on the sober home's medical claim submissions in order to bill the FEHBP and other health insurance programs.

In addition, the owner was alleged to have bought multiple units in a Florida condominium complex, and then provided kickbacks and bribes in the form of free or reduced rent when patients agreed to attend drug treatment at other facilities. The owner of the sober home allegedly hired doctors to order drug testing regardless of whether the testing was medically necessary or conducted on a systematic basis. The FEHBP has paid approximately $800,000 in claims.

Owner of a FL sober home indicted after FEHBP paid $800,000 in potentially medically unnecessary claims.

The owner and co-conspirators are currently awaiting trial.

Illinois Doctor Guilty of Opioid Distribution While Overseas

Acting upon a referral from the National Health Care Anti-Fraud Association (NHCAA),[6] our office investigated allegations that a northern Illinois doctor was billing for services not rendered while he was traveling outside of the continental United States. An additional allegation claimed that his office dispensed prescriptions for opioids without his supervision.

The investigation found that his employees issued prescriptions for Schedule II controlled substances (*e.g.*, oxycodone, opium, hydrocodone, and fentanyl) to his patients while he was out of the country and therefore not able to render the services during several dates between 2008 and 2014. The investigation also found that the doctor submitted fictitious patient progress notes to Federal agents in response to a Federal grand jury subpoena.

Doctor sentenced for health care fraud and ordered to pay the Federal Government approximately $150,000.

The doctor was charged, pled guilty, and in September 2018 was sentenced for violating criminal health care fraud and falsification of records statutes. He was ordered to pay restitution totaling $147,687 to all victims,

[5] These plans are GEHA, MHBP, RCBP, and NALC.
[6] The NHCAA is a national public-private partnership focused on combatting health care fraud.

including the FEHBP. This case was investigated jointly with the FBI and the U.S. Department of Health and Human Services (HHS) OIG.

Urine Drug Testing Scheme Leads to Fraud Conviction

Two Maryland physicians operating a pain management clinic in Maryland were involved in an illegal kickback scheme and committing health care fraud. Our investigation found that the doctors' patients were routinely required to provide urine samples to determine what drugs, if any, were present in the patients' bloodstreams. The urine samples would then be sent for testing to a certain drug-screening laboratory, the former owner of which had entered into an unlawful kickback agreement with the physicians, who received approximately $1.37 million in unlawful remunerations as a part of the scheme.

Maryland pain specialist ordered to pay over $90,000 to the FEHBP and sentenced to 8 years in jail.

The pair also committed health care fraud relating to anesthesia services, by falsely causing medical claims to be submitted that indicated two physicians were present during the performance of nerve blocks and other surgical procedures involving patients with spinal conditions, when there was actually only one physician present. Following a grand jury indictment, one of the physicians committed suicide while the other pleaded guilty, and in September 2018 was sentenced to 96 months incarceration. The surviving physician was also ordered to pay $90,825 in restitution to the FEHBP. This case was investigated jointly with the HHS OIG.

INVESTIGATIVE PRIORITY: IMPROPER PAYMENTS

An improper payment is any payment that should not have been made or that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The two OPM programs that struggle the most with improper payments are the FEHBP and the Retirement Programs. In FY 2017, OPM reported that these two programs made over $341 million in combined improper payments.

Improper Payments in the FEHBP

The Office of Investigations created the FEHBP Fraud, Waste and Abuse (FWA) Task Force in 2007. Membership is open to all FEHBP contracted carriers, sub-contracted Pharmacy Benefit Managers (PBMs), and other public and private health care payers. The primary purpose of the FEHBP FWA Task Force is to engage the carriers' fraud prevention staff responsible for protecting the integrity of the FEHBP to share information related to health care fraud impacting the program, strengthen OPM's FWA program compliance, engage in FEHBP-related FWA proactive/reactive data collection, and identify improper payments related to specific program vulnerabilities.

As part of OPM's FEHBP FWA contractual requirements and its anti-fraud program guidelines described in OPM's Carrier Letter 2017-13,[7] the OIG helps provide oversight of the FEHBP carriers' FWA reporting. Carrier Letter 2017-13 also authorizes the OIG to review carriers' settlement agreements with providers when improper payments associated with FWA are identified within the FEHBP. In FY 2018, FEHBP carriers submitted 21 settlement agreements to the OIG, 18 of which the OIG did

[7] OPM publishes carrier letters to issue binding guidance regarding the FEHBP contracts.

not object to,[8] and which resulted in over $1.1 million of improper payments being returned to the FEHBP.[9]

The cases summarized below demonstrate the various other types of health care fraud we investigate.

California Chiropractor Admits to False Health Care Claims

Chiropractor ordered to pay $97,000 for submitting bills for treatments when his patients were not physically in California.

In July 2018, a Menlo Park, California chiropractor was sentenced to nine months' incarceration and home confinement and ordered to pay approximately $97,000 in restitution after accepting responsibility for submitting for payment fraudulent medical claims to the FEHBP and other health insurance programs. Acting upon a referral, our criminal investigators conducted a search warrant of the chiropractors' medical practice and determined that the chiropractor billed for nearly 300 dates of service as if he was providing medical treatments from his Menlo Park office, when in fact his patients were not physically present in the United States. This case was investigated jointly with the San Mateo County District Attorney's Office.

Florida Ophthalmologist Sentenced to 17 Years in Prison and Ordered to Pay over $42.6 Million

This investigation arose from allegations that a Palm Beach, Florida ophthalmologist, who specialized in the treatment of retinal disorders, knowingly submitted fraudulent claims to Federal health care programs for payment to which he was not entitled. Specifically, it was alleged that the doctor engaged in a scheme to defraud the FEHBP, Medicare, TRICARE, and other health care benefit programs by falsely diagnosing patients with macular degeneration and then performing and billing for excessive and medically unnecessary tests and procedures, which included injections of expensive drugs and laser treatments. Furthermore, the doctor frequently billed for tests and treatment on the prosthetic eyes of one-eyed patients, as if they were real. In addition, the doctor also split single-use vials of expensive eye drugs into multiple doses and billed separately for each injection.

Ophthalmologist found guilty by a Federal jury of 67 counts of health care fraud.

The doctor was charged in a 67-count indictment in April 2015. Two years later, after a seven-week trial, he was found guilty on all counts. In February 2018, the doctor was sentenced to 17 years in Federal prison and was ordered to pay $42.6 million in restitution to Medicare. In April 2018, the judge also ordered the doctor to pay restitution to the other victims, resulting in the return of over $1 million to the FEHBP.

Improper Payments in the Retirement Programs

As part of our oversight work of OPM's Retirement Programs, the Office of Investigations engages in proactive analysis to determine if the OPM Retirement Services office is correctly paying Federal annuitants. Our analysis is informed by applicable Federal

[8] The OIG is supposed to review all carrier settlement agreements where the FEHBP identified loss is over $20,000. If the OIG determines an agreement may interfere with an ongoing criminal or civil healthcare fraud investigation, or is not an equitable recovery for the program, we may remove FEHBP funds from a proposed carrier settlement agreement and pursue our own recovery through DOJ. Additionally, some carrier settlement agreements are not submitted timely to us, and so consequently cannot be reviewed by the OIG. However, the recovery is documented within the OIG's tracking system for reporting purposes.

[9] This figure does not include carrier settlement agreements where a recovery is made, but where the OIG still has an ongoing criminal or civil investigation. Those recoveries are described in another section of this Semiannual Report.

law and regulation, as well as program office policies and procedures.

Our work in this arena has repeatedly demonstrated that improper payments plague OPM's Retirement Programs. Unfortunately, overpayments often continue for many years before being identified. This makes recovery and prosecution difficult, given issues such as statutes of limitations and the age and condition of evidence needed to prosecute.

Below are examples of proactive projects that our Office of Investigations has undertaken to combat overpayments in OPM's Retirement Programs.

- ***Survivor annuitants who have remarried prior to turning 55 years old:*** A Federal annuitant may elect to have his or her surviving spouse receive what is called a "survivor annuity" after the annuitant's death. This survivor annuity continues to the end of the month before the one in which the surviving spouse dies or remarries prior to age 55 (unless the surviving spouse was married to the deceased annuitant for more than 30 years). Retirement Services conducts an annual survey of all survivor annuitants under age 55 to determine if they have remarried. We recently used marriage and divorce records from a commercial records database to review a sample of the survivor annuitants under the age of 55 to determine if there was an indication of remarriage, which would make them ineligible for benefits. We also used open sources and social media to confirm remarriage. We developed several cases (totaling over $646,000) based on our findings.

The OIG identified over $646,000 in improper payments made to remarried survivor annuitants.

- ***Survivor annuitants whose annuity was terminated by Retirement Services due to their remarriage:*** We reviewed survivor annuitants' retirement files and pay histories to determine whether or not Retirement Services recovered annuities paid to survivors after they lost eligibility due to their remarriage. We found several cases where Retirement Services had stopped the annuity payments, but had not calculated and recovered the annuity paid after the remarriage. The recoveries from these cases totaled close to $230,000.
- ***Suspended annuities:*** Retirement Services suspends an annuitant's payments if his or her eligibility to receive benefits comes into question. A case typically remains in this "suspend" status only until OPM can determine whether to restore the annuity or stop payments permanently. We obtained a listing of annuitants whose retirement annuities were suspended by Retirement Services for various reasons and have remained in a suspend status for an extended period of time. We used online investigation software and internet websites such as Legacy.com and findagrave.com for death records to determine whether the annuitant was in fact deceased. We found several annuitants who were deceased but still listed on OPM's suspended file. This is problematic because it means that OPM has not attempted to recover any improper payments made after the deceased annuitant passed away.

Below are summaries of cases that are representative of the other types of retirement annuity fraud we often encounter.

California Woman Steals Deceased Grandfather's Retirement Annuity

A San Diego, California woman, the step-granddaughter of a retired civil servant, stole nearly $400,000 in civil service retirement annuity payments intended for her grandfather. The grandfather's death in 1997 was not reported to the OPM and payments continued into his bank account through December 2014. Acting upon a referral, our office initiated

Granddaughter sentenced to 5 years' probation and ordered to pay OPM close to $400,000.

an investigation and found evidence that the woman accessed her grandfather's bank account after his death and wrote checks to herself by forging her grandfather's signature. The woman was indicted, pled guilty to Federal identity theft charges, and in May 2018 was sentenced to five years' probation. She was also ordered to pay restitution to OPM in the amount of $392,902.32.

Daughter Indicted for Stealing Deceased Mother's Annuity

Our office received a referral from OPM's Retirement Inspections group regarding an annuitant whose 2012 death was never reported to OPM. As a result, OPM continued to electronically deposit monthly payments in the annuitant's bank account, resulting in an overpayment of over $86,200. The agency was able to recover approximately $8,800 through the reclamation process through the Department of the Treasury, leaving a balance of $77,400. We initiated an investigation and determined that the annuitant's daughter was a joint owner of the account, and that she had been using the funds deposited by OPM for her own personal expenses. The daughter had also written checks to her husband and a loan company, signing her deceased mother's name on the checks. In August 2018, the daughter was indicted in Maryland for theft of Government property and identity theft.

INVESTIGATIVE PRIORITY: NATIONAL SECURITY

The National Background Investigations Bureau (NBIB), established on October 1, 2016, conducts background investigations on Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. While a phased transfer of this function to the U.S. Department of Defense is planned to begin in 2020, the NBIB currently conducts 95 percent of all personnel background investigations for the Federal Government. The integrity of these background investigations is crucial to ensuring that only trustworthy individuals have access to sensitive and classified information.

Below are summaries of cases that are representative of the NBIB-related investigations we conduct.

Former OPM Background Investigator Defrauded Elderly Veteran while Employed at the Department of Veterans Affairs

In December 2017, our office was contacted by the U.S. Attorney's Office for the Eastern District of Tennessee to investigate an NBIB background investigator for allegedly submitting false and fraudulent documentation during his own background investigation in order to secure employment with NBIB in 2016. He did this to receive a favorably adjudicated background investigation for a Top Secret security clearance. These allegations were initially developed by DOJ during the course of an ongoing criminal investigation looking into the individual for committing fraud against his former employer, the U.S. Department of Veterans Affairs (VA).

Former NBIB background investigator who lied on his OPM job application is convicted of defrauding a veteran while employed at Dept. of Veterans Affairs.

Our investigation confirmed that, while acting as a field examiner for the VA in 2015, this individual schemed to defraud a disabled and mentally incompetent veteran of over $680,000. Under the VA's Fiduciary Program, field examiners are employed to help protect the financial assets of veterans who are

unable to take care of themselves. As such, field examiners conduct on-site fact-finding examinations to ascertain the veteran's income and assets and to observe his mental condition, living arrangement, and social adjustment. While assigned to a disabled veteran in Knoxville, Tennessee, this individual used his position to convince the veteran that he needed a will. He then drafted the will and inserted his own name as the sole beneficiary of the veteran's financial bank accounts and investments, which totaled over $680,000. The individual falsified the victim's initials on the will and mailed it to the victim's legal guardian. As a result of this fraudulent conduct, he was forced to resign from the VA.

In early 2016, the individual applied for a position as a background investigator for the NBIB in order to conduct background investigations for positions of public trust and security clearances. In his application for the job and security clearance (Standard Form 86), he lied about his own educational and employment history. For example, he falsely claimed that he had received a college degree from the fictitious "Canterbury University" and intentionally withheld that he had been forced to resign from the VA for misconduct. By his misrepresentations and omissions, he was hired for the job and worked for NBIB through 2017.

In July 2018, following a six-day trial in the U.S. District Court for the Eastern District of Tennessee, the former NBIB background investigator was convicted of wire fraud, mail fraud, financial conflict of interest, theft of public money, and making false statements in matters within the jurisdiction of the United States. He is currently awaiting sentencing.

Former Contractor Background Investigator Pleads Guilty and Is Sentenced

Former background investigator sentenced and ordered to pay OPM over $77,000.

Our office received a case referral from the NBIB Integrity Assurance office alleging that a former contractor background investigator falsified several Reports of Investigations (ROIs). The referral resulted from a review conducted by the Integrity Assurance office of all of the former background investigator's cases from April 2013 to September 2013, and found that he falsified 55 source interviews.

In June 2018, in the U.S. District Court for the District of Columbia, the former background investigator entered a plea of guilty to one count of making a false statement. In August 2018, he was sentenced to one month of incarceration; 24 months of supervised release, to include 5 months of home detention following his incarceration; and was ordered to pay a restitution in the amount of $77,649 for the reinvestigations of the background investigations he fabricated.

NBIB Contractor Background Investigator Falsified Reports of Investigation

In August 2017, we received a case referral from the NBIB Integrity Assurance office alleging that a former contractor background investigator submitted false and inaccurate ROIs when conducting the background investigations of multiple individuals, dating from November 2016 to August 2017.

Our investigation confirmed that the former background investigator falsified at least four ROIs. DOJ declined to prosecute the case criminally, allowing OPM to pursue an administrative offset and recovery action. Our Office of Investigations submitted an

administrative referral to the OPM Suspension and Debarment Committee in October 2017 for their action. In August 2018, an administrative contract offset in the amount of $100,066, was executed against the contractor that had employed the background investigator. This offset cost is the direct costs associated with the NBIB Integrity Assurance office's reinvestigation efforts.

INVESTIGATIVE PRIORITY: INTEGRITY OF OPM PROGRAMS AND OPERATIONS

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations of fraud, waste, abuse, or mismanagement at OPM. Below are summaries of some notable cases.

Former Employee of an FEHBP Carrier Indicted

In January 2015, we were contacted by the U.S. Department of Labor (DOL) OIG concerning allegations that a company was providing cosmetic services such as hair removal, massages, microdermabrasion, botox, and facials, but billing health insurance programs for medical procedures in order to receive reimbursement for medical claims.

It was alleged that the company induced patients to visit clinics to receive free cosmetic procedures, which were not covered by health insurance. In exchange for receiving the free services, health insurance information was obtained from the patients and used to fraudulently bill health insurance plans for unnecessary medical services and for services that were never provided.

A former employee of an FEHBP carrier helped conceal fraud committed by local clinics.

It is alleged that in return for cash payments, an employee in an FEHBP carrier's anti-fraud unit assisted the owner of the company and others by providing them with confidential carrier information that helped them submit fraudulent medical bills to the carrier. In September 2012, the carrier's employee gave the owner of the company health insurance billing codes that the carrier employee knew could be used to submit fraudulent medical claims to the carrier without detection. Additionally, the carrier's employee allegedly also helped to prevent his employer and other health insurance carriers from discovering the fraud and pursuing investigations of the clinics.

As a result of the referral, we contacted the largest FEHBP carriers to obtain exposure related to paid claims for services billed by the company. Approximately $201,738 has been paid as a result of medical claims submitted to the FEHBP.

In May 2018 the owner of the company, the employee of the FEHBP carrier, and other co-conspirators were indicted and later arrested. The case is scheduled for trial in January 2019. This case is being investigated jointly with DOL OIG.

OPM Employee Misused Purchase Card

In June 2017, the OPM Office of Procurement Operations reported to the OIG that an employee misused a Government purchase card. Specifically, it was alleged the employee fraudulently processed a total of four personal charges on their Government-issued purchase card. The four transactions were listed as "Property Payment – Rent" and the charges totaled $4,399.

Our investigators substantiated the allegations made against the employee, upon completing the investigative review of credit card statements, other financial records, witness interviews, and obtaining a signed

sworn written statement of admission from the employee. The U.S. Attorney's Office for the District of Columbia and State's Attorney's Office for Prince George's County, Maryland, declined to prosecute the matter criminally. The matter was referred to OPM for consideration of administrative action, and the agency will be required to report the outcome of its administrative action(s) to our office.

Unsubstantiated Allegations Concerning Senior Government Employees

Section 5(a)(22)(B) of the Inspector General Act of 1978, as amended, requires our office to describe investigations involving a senior Government employee that were closed and not disclosed to the public.

During this reporting period, we received allegations that a senior Government official within OPM may have inappropriately purchased promotional items using appropriated funds. Our investigation determined that no such purchases had been made using appropriated funds and the case was closed.

OIG HOTLINE ACTIVITY

The OIG's Fraud Hotline also contributed to identifying fraud and abuse. The Hotline telephone number and mailing address are listed on our 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 annuity 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 1,562 hotline inquiries during the reporting period, and closed 616. The table on page 35 reports the summary of hotline activities received through telephone calls, emails, and letters.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority, 5 U.S.C. § 8902a, we suspend or debar health care providers whose actions demonstrate that they are not sufficiently responsible to participate in the FEHBP. At the end of this reporting period, there were 35,653 active debarments and suspensions of health care providers from the FEHBP.

During the reporting period, our office issued 337 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 2,311 sanctions-related inquiries from other Government entities, FEHBP carriers, private companies, and health care providers.

> ***Debarment*** *disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. The FEHBP has 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 the provider 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 Office of Investigations;
- Cases identified by our administrative sanctions team through systematic research and analysis of electronically available information about health care providers; and
- Referrals from other sources, including health insurance carriers and state regulatory and law enforcement agencies.

Administrative sanctions serve a protective function for the FEHBP and Federal employees, annuitants, and their dependents who obtain their health insurance coverage through the FEHBP.

The following cases handled during the reporting period highlight the importance of the Administrative Sanctions Program.

North Carolina Physician Debarred after Indefinite Suspension of His License

In June 2018, our office debarred a North Carolina physician based on the North Carolina Medical Board's decision to indefinitely suspend the physician's license. In March 2014, the Medical Board indefinitely suspended the physician's license to practice medicine based upon its findings that he failed to conform to the standards of acceptable and prevailing medical practice within the meaning of North Carolina law.

The physician was a pain management specialist, and the owner of a health care facility. The Medical Board found the physician and his staff provided substandard care in the treatment of several patients diagnosed with chronic pain. All of the patients received

controlled substances and interventional procedures for their pain management therapy. The Medical Board determined that the physician:

- Escalated opioid therapy without adequate justification, appropriate diagnosis, or evidence of increased pain;
- Provided incomplete medical examinations;
- Falsified treatment records; and
- Failed to observe pharmacovigilance in recognizing or properly responding to evidence of drug abuse or diversion.

The physician has been debarred for an indefinite period from participating in the FEHBP. This case was referred to us by our Office of Investigations.

Florida Physician and Two Medical Facilities Debarred from the FEHBP for Health Care Fraud

In July 2018, we debarred a Florida physician based on his conviction in the U.S. District Court for the Southern District of Florida on one count of obstruction of a criminal health care investigation and one count of health care fraud.

Doctor was debarred after pleading guilty to obstruction and producing falsified records in response to a Federal grand jury subpoena.

The Government initiated an investigation into the physician's billing practices after a lawsuit filed by a Palm Beach County dermatologist alleged the physician had falsely diagnosed patients with skin cancer. The dermatologist further alleged that the physician subjected his patients to medically unnecessary radiation treatments when in fact their skin ailments were either benign freckles or warts.

The Government's investigation found that the physician charged for biopsies and radiation treatments that were either unnecessary or not rendered. In addition, his patients were not properly cared for because he allowed unqualified medical staff members to perform procedures that they had not been trained to do.

In February 2017, the Government and the physician entered into a settlement of the civil suit resulting in an $18 million judgment in favor of the United States. The Government subsequently agreed to accept the physician's payment of $6 million to settle the civil suit and criminal cases.

In December 2017, the physician pleaded guilty to committing the crimes of obstructing a Federal health care fraud investigation by delivering falsified and altered patient files that had been subpoenaed by a Federal grand jury. The physician also admitted to submitting approximately $350,000 in false claims to health care benefits programs including Medicare, Tricare, Railroad Retirement Board's Medicare Program, FEHBP, and other insurers.

In February 2018, the physician was sentenced to 36 months of imprisonment, to be followed by one year of supervised release. As a result of this conviction, he was required to permanently surrender his license to practice as an osteopathic physician, and is not allowed to own, operate, manage, or consult in a medical practice.

Under the FEHBP's administrative sanctions statutory authority, convictions related to fraud in connection with the delivery of a health care service or supply and convictions in connection with the obstruction of a health care fraud investigation constitute a mandatory basis for debarment. Therefore, we debarred the physician and two medical facilities that were used in committing the fraud from participating in the FEHBP. This case was referred to us by our Office of Investigations.

Evaluation Activities

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

We did not issue any evaluation reports during this reporting period.

Legal & 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. Our Office of Legal & 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. We also submit comments on proposed and draft legislation to both Congress and the CIGIE Legislative Committee.

COMBATTING KICKBACKS

In past Semiannual Reports to Congress, we have discussed some of the problems arising from the FEHBP's exclusion from the Anti-Kickback Statute.[10] However, the recent enactment of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Pub. L. 115-271, promises to ameliorate this deficiency.

The Eliminating Kickbacks in Recovery Act will prohibit certain types of kickbacks in the FEHBP.

The Act, which was signed by the President on October 24, 2018 incorporates the Eliminating Kickbacks in Recovery Act of 2018 (EKRA), which creates a new prohibition on certain types of medical kickbacks. In the absence of the broader protection of the Anti-Kickback Statute, the EKRA provides similar protections that *will* extend to the FEHBP. However, the new prohibitions apply to a limited subset of kickback schemes that have seen increased use during the opioid crisis—kickbacks paid in exchange for referrals to or use of a recovery home, clinical treatment facility, or laboratory.

Accordingly, while the OPM OIG expects to vigorously pursue violations of the EKRA, amendment of the Anti-Kickback Statute is still needed to adequately safeguard the FEHBP and its enrollees.

MESSAGE ON AGENCY COOPERATION

As discussed in previous Semiannual Reports to Congress, cooperation between the OIG and OPM employees is critical to the OIG's mission. During the reporting period, the OIG consulted with the Office of the Director regarding an agency-wide announcement reaffirming that all OPM employees are expected to cooperate with OIG requests for information. We are pleased to report that then-Director Pon issued

[10] The Anti-Kickback Statute generally prohibits the knowing and willful payment of anything of value in exchange for the referral of a patient or generation of business for items or services payable by a "Federal health care program," excluding the FEHBP.

such an announcement on September 12, 2018. As Dr. Pon wrote, "It is essential that OPM and the OIG collaborate to ensure the best interest of the American people. Cooperation with the OIG allows OPM to address operational weaknesses and improve the performance of OPM programs through corrective action."

Statistical Summary of Enforcement Activities

INVESTIGATIVE ACTIONS AND RECOVERIES:

Indictments and Informations	51
Arrests	37
Convictions	34
Criminal Complaints/Pre-Trial Diversion	2
Subjects Presented for Prosecution	83
Federal Venue	80
Criminal	51
Civil	29
State Venue	3
Local Venue	0
Expected Recovery Amount to OPM Programs	$17,220,493
Civil Judgments and Settlements	$11,293,917
Criminal Fines, Penalties, Assessments, and Forfeitures	$2,902,972
Administrative Recoveries	$3,023,604
Expected Recovery Amount to All Programs and Victims[11]	$811,566,617

INVESTIGATIVE ADMINISTRATIVE ACTIONS:

FY 2018 Investigative Reports Issued[12]	334
Issued between October 1, 2017 – March 31, 2018	206
Issued between April 1, 2018 – September 30, 2018	128
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	19
Health Care Cases Referred to the OIG for Suspension and Debarment	18
NBIB Cases Referred to OPM for Suspension and Debarment	1
Personnel Suspensions and Terminations	0
Referral to the OIG's Office of Audits	1

ADMINISTRATIVE SANCTIONS ACTIVITY:

FEHBP Debarments and Suspensions Issued	337
FEHBP Provider Debarment and Suspension Inquiries	2,311
FEHBP Debarments and Suspensions in Effect at End of Reporting Period	35,653

[11] This 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.

[12] The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports. The total reports issued and the breakout between Semiannual Report periods has been included to amend the previous submission total and reflect totals using a consistent and more accurate methodology.

OIG Investigative Case Activity

	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened	**408**	**65**	**16**	**5**	**494**
Investigations	41	14	2	3	60
Complaints	367	51	14	2	434
Inquiries Opened	**801**	**54**	**5**	**5**	**865**
Referrals - FEHBP Carriers/Program Office	581	15	4	0	600
Referrals - All Other Sources/Proactive	220	39	1	5	265
Cases Closed	**83**	**28**	**25**	**1**	**137**
Investigations	59	15	8	0	82
Complaints	24	13	17	1	55
Inquiries Closed[13]	**57**	**808**	**12**	**8**	**885**
Referrals - FEHBP Carriers/Program Office	13	481	4	0	498
Referrals - All Other Sources/Proactive	44	327	8	8	387
Cases In-Progress[14]	**520**	**71**	**32**	**2**	**625**
Investigations	175	43	18	1	237
Complaints	345	28	14	1	388
Inquiries In-Progress[15]	**348**	**14**	**1**	**0**	**363**
Referrals - FEHBP Carriers/Program Office	335	4	0	0	339
Referrals - All Other Sources/Proactive	13	10	1	0	24

[13] Cases closed may have opened in a previous reporting period.
[14] Cases in-progress may have been opened in a previous reporting period.
[15] Inquiries in-progress may have been opened in a previous reporting period.

OIG Hotline Case Activity

OIG Hotline Cases Received 1,562

Sources of OIG Hotline Cases Received

- Website 799
- Telephone 564
- Letter 117
- Email 78
- In-Person 4

By OPM Program Office

- Healthcare and Insurance 265
  - Customer Service 184
  - Billing Disputes 42
  - Other Healthcare and Insurance Issue 39
- Retirement Services 351
  - Customer Service 247
  - Annuity Calculation 68
  - Other Retirement Services Issues 36
- Other OPM Program Offices/Internal Matters 138
  - Customer Service 111
  - Other OPM Program/Internal Issues 19
  - Employee or Contractor Misconduct 8
- External Agency Issue (not OPM-related) 808

OIG Hotline Cases Reviewed and Closed 616

Outcome of OIG Hotline Cases Closed

- Referred to External Agency 315
- Referred to OPM Program Office 214
  - Retirement Services 159
  - Healthcare and Insurance 28
  - Other OPM Programs/Internal Matters 27
- No Further Action 77
- Converted to a Case 10

OIG Hotline Cases Pending[16] 946

By OPM Program Office

- Healthcare and Insurance 210
- Retirement Services 156
- Other OPM Program Offices/Internal Matters 81
- External Agency Issue (not OPM related) 499

[16] Includes hotline cases pending an OIG internal review or an agency response to a referral.

Appendices

APPENDIX I - A

Final Reports Issued With Questioned Costs for Insurance Programs
April 1, 2018 to September 30, 2018

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	4	$87,024,512
B.	Reports issued during the reporting period with findings	7	$16,506,487
	Subtotals (A+B)	11	$103,530,999
C.	Reports for which a management decision was made during the reporting period:	8	$30,505,575
	1. Disallowed costs	N/A	$25,140,891
	2. Costs not disallowed	N/A	$5,364,684[1]
D.	Reports for which no management decision has been made by the end of the reporting period	3	$73,025,424
E.	Reports for which no management decision has been made within 6 months of issuance	3	$73,025,424

[1] Represents 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 Reports Issued With Questioned Costs for All Other Audited Entities

April 1, 2018 to September 30, 2018

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

APPENDIX II

Resolution of Questioned Costs in Final Reports for Insurance Programs

April 1, 2018 to September 30, 2018

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$144,742,074
B.	Value of new audit recommendations issued during the reporting period	$16,506,487
	Subtotals (A+B)	$161,248,561
C.	Amounts recovered during the reporting period	$20,406,567
D.	Amounts allowed during the reporting period	$29,516,742
E.	Other adjustments	$0
	Subtotals (C+D+E)	$49,923,309
F.	Value of open recommendations at the end of the reporting period	$111,325,252

APPENDIX III

Final Reports Issued With Recommendations for Better Use of Funds

April 1, 2018 to September 30, 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
April 1, 2018 to September 30, 2018

Report Number	Subject	Date Issued	Questioned Costs
1A-10-32-17-009	Blue Cross Blue Shield of Michigan in Detroit, Michigan	April 24, 2018	$27,745
1C-X5-00-17-032	HealthPlus of Michigan in Flint, Michigan	April 24, 2018	$0
1C-52-00-17-031	Health Alliance Plan in Southfield, Michigan	May 10, 2018	$0
1B-31-00-17-041	Government Employees Health Association, Inc. in Lee's Summit, Missouri	May 10, 2018	$3,660,811
1D-87-00-17-038	Hawaii Medical Service Association in Honolulu, Hawaii	June 11, 2018	$1,208,306
1J-0C-00-18-030	Federal Employees Dental and Vision Insurance Program Premium Rate Proposal of FEP BlueDental for 2019 in Eagan, Minnesota	July 30, 2018	$0
1J-0F-00-18-027	Federal Employees Dental and Vision Insurance Program Premium Rate Proposal of MetLife for 2019 in Bridgewater, New Jersey	August 2, 2018	$0
1H-06-00-17-026	Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2012 through 2015 in St. Louis, Missouri	August 16, 2018	$20,476
1J-0M-00-18-002	Federal Employees Dental and Vision Insurance Program Operations as Administered by Delta Dental of California for Contract Years 2014 through 2016 in Rancho Cordova, California	August 28, 2018	$0
1A-10-33-18-001	BlueCross BlueShield of North Carolina in Durham, North Carolina	August 28, 2018	$4,231,513
1A-99-00-17-048	Global Audit of Claims-to-Enrollment Match for Blue Cross and Blue Shield Plans in Washington, D.C.	August 28, 2018	$7,347,355
1J-0L-00-17-051	Federal Employees Dental and Vision Insurance Program Operations as Administered by EmblemHealth Dental for Contract Years 2014 through 2016 in New York, New York	September 21, 2018	$10,281
TOTAL			**$16,506,487**

APPENDIX V

Internal Audit Reports Issued
April 1, 2018 to September 30, 2018

Report Number	Subject	Date Issued
4A-HI-00-17-025	U.S. Office of Personnel Management's Oversight of the Rate Monitoring and Procurement Process of the Federal Long Term Care Insurance Program in Washington, D.C.	April 5, 2018
4A-CF-00-18-012	U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018
4A-CF-00-17-050	U.S. Office of Personnel Management's Personnel Security Adjudications Process in Washington, D.C.	August 20, 2018

APPENDIX VI

Information Systems Audit Reports Issued
April 1, 2018 to September 30, 2018

Report Number	Subject	Date Issued
1A-10-53-17-042	Information Systems General and Application Controls at Blue Cross Blue Shield of Nebraska in Omaha, Nebraska	April 17, 2018
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018
1C-PG-00-17-045	Information Systems General and Application Controls at Optima Health Plan in Virginia Beach, Virginia	May 10, 2018
4A-PP-00-18-011	Information Technology Security Controls of the U.S. Office of Personnel Management's Health Claims Data Warehouse in Washington, D.C.	June 25, 2018
1A-10-11-17-052	Information Systems General and Application Controls at Blue Cross Blue Shield of Massachusetts in Boston, Massachusetts	August 23, 2018

APPENDIX VII

Management Advisories Issued
April 1, 2018 to September 30, 2018

Report Number	Subject	Date Issued
4A-CI-00-18-044	U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, D.C.	June 20, 2018

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, D.C.	September 23, 2008	2	19
4A-CF-00-08-025	The U.S. Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements in Washington, D.C.	November 14, 2008	1	6
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, D.C.	November 5, 2009	2	30
4A-CF-00-09-037	The U.S. Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statements in Washington, D.C.	November 13, 2009	1	5
4A-CF-00-10-015	The U.S. Office of Personnel Management's Fiscal Year 2010 Consolidated Financial Statements in Washington, D.C.	November 10, 2010	3	7
4A-CI-00-10-019	Federal Information Security Management Act for Fiscal Year 2010 in Washington, D.C.	November 10, 2010	2	41
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.	September 14, 2011	3	14
4A-CI-00-11-009	Federal Information Security Management Act for Fiscal Year 2011 in Washington, D.C.	November 9, 2011	3	29
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, D.C.	November 14, 2011	1	7
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, D.C.	November 5, 2012	4	18

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, D.C.	November 15, 2012	1	3
1K-RS-00-12-031	The U.S. Office of Personnel Management's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.	December 12, 2012	1	2
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013	5	16
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1	1
4A-CI-00-14-015	Information Technology Security Controls of the U.S. Office of Personnel Management's Development Test Production General Support System Fiscal Year 2014 in Washington, D.C.	June 6, 2014	2	6
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	3	4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	15	29
4K-RS-00-14-076	The Review of the U.S. Office of Personnel Management's Compliance with the Freedom of Information Act in Washington, D.C.	March 23, 2015	2	3

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-RS-00-13-033	Assessing the Internal Controls over the U.S. Office of Personnel Management's Retirement Services' Retirement Eligibility and Services Office in Washington, D.C.	April 13, 2015	1	7
4A-HR-00-13-055	The Human Resources Solutions' Pricing Methodologies in Washington, D.C.	June 2, 2015	1	5
4A-CI-00-15-055	Flash Audit Alert – the U.S. Office of Personnel Management's Infrastructure Improvement in Washington, D.C.	June 17, 2015	1	2
1A-99-00-14-046	Global Coordination of Benefits for Blue Cross and Blue Shield Plans in Washington, D.C.	July 29, 2015	1	5
4A-RI-00-15-019	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015	4	7
4A-RI-00-16-014	Management Alert of Serious Concerns Related to the U.S. Office of Personnel Management's Procurement Process for Benefit Programs in Washington, D.C.	October 14, 2015	1	4
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	16	27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	5	5
1A-10-17-14-037	Health Care Service Corporation in Chicago, Illinois	November 19, 2015	3	16

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4K-RS-00-16-024	The Office of the Inspector General's Special Review of the U.S. Office of Personnel Management's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group LLC, and its subcontractor, CSIdentity in Washington, D.C.	December 2, 2015	2	2
1A-99-00-15-008	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.	January 21, 2016	1	8
4A-CF-00-16-026	The U.S. Office of Personnel Management's Fiscal Year 2015 Improper Payments Reporting in Washington, D.C.	May 11, 2016	1	6
4A-CI-00-16-037	Second Interim Status Report on the U.S. Office of Personnel Management's Infrastructure Improvement Project - Major IT Business Case in Washington, D.C.	May 18, 2016	2	2
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, D.C.	July 8, 2016	6	6
1C-L4-00-I6-013	HMO Health Ohio in Cleveland, Ohio	September 23, 2016	2	2
4K-RS-00-16-023	The U.S. Office of Personnel Management's Retirement Services' Customer Service Function in Washington, D.C.	September 28, 2016	2	3
IA-99-00-15-060	Global Coordination of Benefits for Blue Cross and Blue Shield Plans in Washington, D.C.	October 13, 2016	1	3
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	4	4

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	21	26
IA-10-33-15-009	Blue Cross and Blue Shield of North Carolina in Durham, North Carolina	November 10, 2016	4	6
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	15	19
4A-RS-00-16-035	Information Security Controls of the U.S. Office of Personnel Managements Federal Annuity Claims Expert System in Washington, D.C.	November 21, 2016	10	13
4A-CF-00-17-012	The U.S. Office of Personnel Management's Fiscal Year 2016 Improper Payments Reporting in Washington, D.C.	May 11, 2017	1	10
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	4	4
4A-OO-00-16-046	The U.S. Office of Personnel Management's Purchase Card Program in Washington, D.C.	July 7, 2017	12	12
4A-CF-00-17-043	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	September 29, 2017	5	7
4A-CF-00-17-044	Information Technology Security Controls of the U.S. Office of Personnel Management's Federal Financial System in Washington, D.C.	September 29, 2017	9	9

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	8	8
1H-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; 3 total recommendations; 1 open recommendation	October 2, 2017	1	3
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	39	39
4A-CF-00-17-033	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act in Washington, D.C.	November 9, 2017	3	3
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	18	18
1C-ML-00-17-027	Information Systems General and Application Controls at AvMed Health Plan in Miami, Florida	December 18, 2017	4	16
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	21	21
4A-CI-00-18-022	Management Advisory Report - the U.S. Office of Personnel Management's Fiscal Year 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018	4	4

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of September 30, 2018
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
1A-99-00-16-021	Global Veterans Affairs Claims for Blue Cross and Blue Shield Plans in Washington, D.C.	February 28, 2018	5	5
1D-SI-00-17-022	BlueShield of California Access+ HMO in San Francisco, California	February 28, 2018	1	16
4A-OO-00-17-035	The U.S. Office of Personnel Management's Award of a Credit Monitoring and Identity Theft Services Contract to Identity Theft Guard Solutions, LLC in Washington, D.C.	February 28, 2018	2	2
1A-99-00-16-062	Global Coordination of Benefits for Blue Cross and Blue Shield Plans in Washington, D.C.	March 15, 2018	2	5
4A-MO-00-18-004	Information Technology Security Controls of the U.S. Office of Personnel Management's Combined Federal Campaign System in Washington, D.C.	March 29, 2018	4	5
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5	5

APPENDIX IX

Most Recent Peer Review Results
As of September 30, 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 *(Issued by the Office of the Special Inspector General for Afghanistan Reconstruction)*	September 22, 2015	Pass[1]
System Review Report on the NASA Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	August 13, 2018	Pass
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the National Science Foundation *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	December 14, 2017	Compliant[2]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management *(Issued by the Office of Inspector General, Corporation for National and Community Service)*	December 2, 2016	Compliant

[1] A 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.

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

APPENDIX X

Investigative Recoveries
April 1, 2018 to September 30, 2018

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Recovery
Administrative Activities			**$3,106,711**	**$3,023,604**
	Healthcare and Insurance		$1,175,070	$1,166,669
		Collection of Improper Payments	$1,175,070	$1,166,669
	NBIB		$290,156	$290,156
		Contract Off-Sets	$290,156	$290,156
	Retirement Services		$1,641,484	$1,566,778
		Admin Debt Recoveries	$1,230,516	$1,230,516
		Bank Reclamations	$111,426	$111,426
		Collection of Improper Payments	$213,168	$138,462
		Voluntary Payment Agreements	$86,374	$86,374
Civil Activities			**$750,267,762**	**$11,293,917**
	Healthcare and Insurance		$750,267,762	$11,293,917
		Civil Actions	$750,267,762	$11,293,917
Criminal Activities			**$58,192,145**	**$2,902,972**
	Healthcare and Insurance		$57,383,055	$2,094,107
		Court Assessments/Fees	$7,325	-
		Criminal Fines	$240,351	-
		Criminal Judgments/ Restitution	$56,486,070	$1,444,798
	NBIB		$77,749	$77,649
		Court Assessments/Fees	$100	-
		Criminal Judgments/ Restitution	$77,649	$77,649
	Retirement Services		$731,341	$731,216
		Court Assessments/Fees	$125	-
		Criminal Judgments/ Restitution	$731,216	$731,216
Grand Total			**$811,566,617**	**$17,220,493**

Index of Reporting Requirements

(As per the Inspector General Act of 1978, As Amended)

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SEPTEMBER 2018
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