Office of the Inspector General

U.S. Office of Personnel Management

Semiannual Report to Congress

October 1, 2024–March 31, 2025

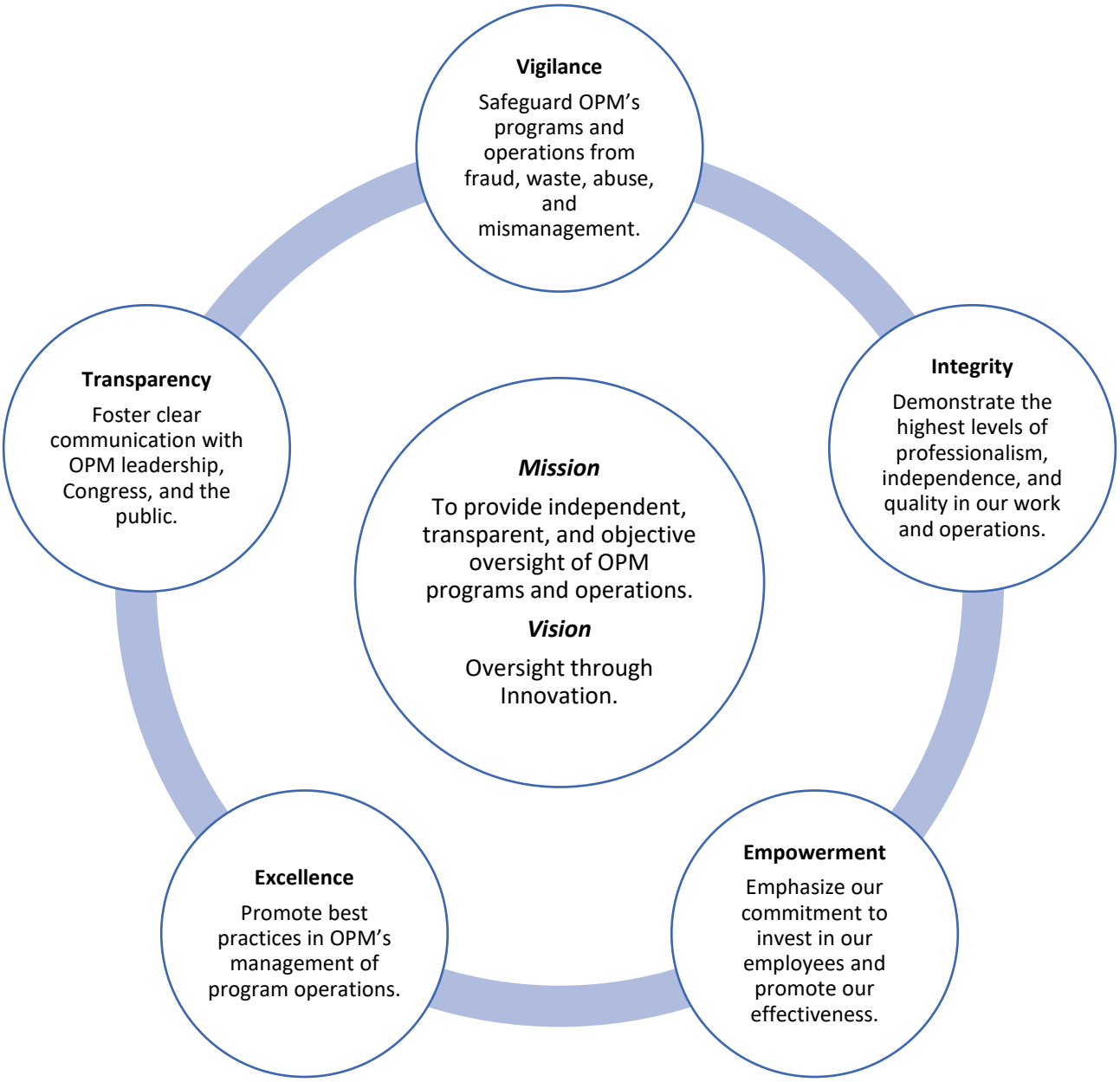
FINANCIAL IMPACT AND ACCOMPLISHMENTS

Audit Recommendations for Recovery of Funds	Management Commitments to Recover Funds	Recoveries Through Investigative Actions
$29,127,430	$36,523,640	$2,747,818

Note: OPM Management Commitments for Recovery of Funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

Audit Reports Issued	Evaluation Reports Issued	Special Review Report Issued	Management Advisories Issued	Investigations and Preliminary Investigations Closed	Indictments and Criminal Informations
12	0	0	0	88	2
4	2	2774	2236	520	1863
Arrests	Convictions	Hotline Contacts and Complaints Received	Hotline Complaints Reviewed & Closed	Debarments and Suspen-sions of Federal Employees Health Benefits Program Providers	Debarment and Suspension Inquiries and Correspondence Related to Federal Employees Health Benefits Program Providers

OIG Strategic Framework



Message From the Deputy Inspector General Performing the Duties of the Inspector General

Federal agencies today are undergoing historic change, and the U.S. Office of Personnel Management (OPM) is no exception. Given this environment, now is a fitting time to reiterate the purpose and mission of federal Offices of Inspectors General (OIGs).

Signed by President Jimmy Carter, the Inspector General Act of 1978 (IG Act) established statutory IGs and authorized them to combat fraud, waste, and abuse within their associated federal agencies. Through the years, the IG Act has been amended to increase the number of agencies with IGs and to further delineate IG authorities to provide independent oversight by conducting audits, evaluations, investigations, and other reviews across the federal government.

OIGs remain one of the government's most effective tools to protect taxpayer dollars and public safety by helping to ensure that government programs work as intended. Through audits, evaluations, and investigations, OIGs follow their statutory mandate to ensure that government services are delivered efficiently and legally. When they find problems, OIGs make recommendations to improve accountability and performance and make reports to their respective agency heads and Congress.

The OPM OIG has a statutorily mandated mission to uphold trust and transparency in government. As such, we publicize our work through our reports, which are delivered to OPM leadership and Congress as well as posted on our website and on Oversight.gov. We also maintain an online open recommendations dashboard to keep Congress and the public apprised of the results of our work and to keep the agency accountable.

The OIG community works to ensure that funds are spent for their intended purposes. Every year, OIGs identify in their reports billions of dollars in potential savings by uncovering fraud, waste, and abuse in federal programs. During this reporting period, OPM OIG audits recovered $29 million to the OPM trust fund, and our investigations recovered $3 million. This means that over the past 5 fiscal years, our audits have recovered $164 million, and our investigations have recovered $91 million, for a combined total of $255 million.

In addition to safeguarding taxpayer dollars, OIGs work to protect public safety. For instance, our law enforcement work over the last 5 years has resulted in 133 arrests, 151 indictments, and 133 convictions. The OPM OIG also suspends or debars health care providers whose actions show that they are not professionally responsible enough to participate in the OPM-administered Federal Employees Health Benefits Program (FEHBP). These direct services to citizens protect the health and safety of federal enrollees, annuitants, and their eligible family members as well as protect the financial integrity of the program. During this reporting period, we suspended or debarred 520 health care providers who committed violations that affect the

FEHBP and its enrollees, resulting in a total of 39,982 health care providers who are suspended or debarred from taking part in the FEHBP at this time.

We also have developed a state-of-the-art capability to obtain sanctions-related information online and integrate it into our decision-making processes. With the nature and extent of electronically accessible information constantly growing, we are now able to search nationwide for violations involving providers directly associated with the FEHBP. We select cases for action based on the seriousness of the provider's violations and the risks that the provider poses to the FEHBP and its members.

The OPM OIG continues to advance our proactive oversight efforts. After the OPM OIG received access to the U.S. Department of the Treasury's Do Not Pay portal in 2024, we began using this data resource to help initiate proactive investigations based on incongruities between the OPM annuity roll and death sources in the Do Not Pay system. We have found 1,200 OPM annuitant records and more than $15 million worth of annual annuity payments for review. We have already recovered $421,271 through our investigative efforts, including an $87,000 recovery during this semiannual reporting period. We continue to use our various data resources, such as the Do Not Pay portal and FEHBP medical claims, to generate impactful criminal, civil, and administrative investigations and protect the integrity of OPM programs. We also use FEHBP medical claims to audit the FEHBP health plans and pharmacy benefit managers.

One challenge the OPM OIG continues to face is the FEHBP's exclusion from the Anti-Kickback Statute. This is a barrier to recovering potentially millions of dollars in fraud schemes. In this reporting period, we closed investigations that focused exclusively on violations of the Anti-Kickback Statute where the FEHBP had paid more than $1.4 billion in potentially fraudulent claims. While not all of this may be the amount lost to fraud, waste, or abuse, the Anti-Kickback Statute's exclusion of the FEHBP leaves the OPM OIG extremely limited recourse in trying to recover any fraudulently paid money. We continue to work with Congress to advance reforms to include the FEHBP under the Anti-Kickback Statute.

Through independent oversight, OIGs hold federal government officials and programs accountable by providing a more effective, responsive government for the American people. The work we do is critically important for OPM, Congress, the federal government, and the public. Please know that the OPM OIG will continue carrying out our mission: conducting independent oversight with integrity and transparency.

Norbert E. Vint
Deputy Inspector General Performing the
Duties of the Inspector General

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Introduction

The Office of the Inspector General (OIG) is an independent office within the U.S. Office of Personnel Management (OPM). The OPM OIG is dedicated to promoting accountability and transparency both within and outside of the agency. Our mission is to provide independent and objective oversight of OPM services and programs by conducting audits, investigations, evaluations, and other reviews. The recommendations we provide help improve the efficiency and effectiveness of OPM's operations.

We strive for continuous improvement in our agency's management and program operations and in our own offices.

The OPM OIG provides objective oversight and appraisal of the agency's responsibilities and its implementation to assure the integrity, efficiency, and effectiveness of the agency's services.

Our offices are in Washington, DC; Cranberry Township, Pennsylvania; and Jacksonville, Florida.

Figure 1. OIG Office Locations

Audit Activities

The OPM OIG's Office of Audits conducts comprehensive and independent audits of OPM programs, operations, and contractors. These audits assist the OPM Director and Congress by providing credibility and transparency to the information reported by the agency and providing information to improve accountability and facilitate decision-making.

Health Insurance Audits

OPM contracts with Federal Employees Health Benefits Program (FEHBP) health insurance carriers for health benefit plans for federal employees, annuitants, their eligible family members, and other eligible populations. 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 more than 200 audit sites consisting of health insurance carriers, sponsors, and underwriting organizations participating in the FEHBP. The number of audit sites fluctuates due to the addition, nonrenewal, and merger of participating health insurance carriers. Combined premium payments for the FEHBP total more than $55 billion annually. The health insurance carriers audited by the OIG are classified as either community-rated or experience-rated.

Community-rated carriers offer comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs). They are responsible for paying claims and administrative costs incurred, and they are paid an amount commensurate with the number of subscribing FEHBP enrollees and the premiums paid by those enrollees. Consequently, community-rated carriers suffer the loss if the costs incurred by the plan exceed the amount of premiums received.

Experience-rated carriers offer mostly fee-for-service plans (the largest being the Blue Cross and Blue Shield Service Benefit Plan), but they also offer experience-rated HMOs. These carriers are reimbursed for actual claims paid and administrative expenses incurred, and they are paid a service charge determined in negotiation with OPM. Experience-rated carriers will suffer a loss in certain situations if claims exceed amounts available in the Employees Health Benefits Fund, which is a fund in the U.S. Department of the Treasury that holds premiums paid by enrollees and from which carriers are reimbursed for claims paid and expenses incurred.

Community-Rated Health Plans

The community-rated carrier audit universe covers approximately 140 health plans located throughout the country. Community-rated carrier audits are designed to ensure that the premium rates

health plans charge the FEHBP and the medical loss ratios (MLRs) filed with OPM are in accordance with their respective contracts and applicable federal laws and regulations.

Premium Rate Review Audits

Our premium rate review audits focus on the rates set by the health plan and ultimately charged to the FEHBP subscriber, OPM, and taxpayers. When an audit identifies that rates are incorrect, unsupported, or inflated, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Any questioned costs related to the premium rates are subject to lost investment income.

Premium rate review audits of community-rated carriers focus on ensuring that the

- medical and prescription drug claims totals are accurate, and the individual claims are processed and paid correctly;
- FEHBP rates are developed in a model that is filed with and approved by the appropriate state regulatory body or used in a consistent manner for all eligible community groups that meet the same criteria as the FEHBP; and
- rate adjustments applied to the FEHBP rates for additional benefits not included in the basic benefit package are appropriate, reasonable, and consistent.

Medical Loss Ratio Audits

We also perform audits to evaluate carrier compliance with OPM's FEHBP-specific MLR requirements, which are based on the MLR standards established by the Affordable Care Act and apply to most community-rated carriers. State-mandated traditional community-rated carriers are not subject to the MLR regulations and continue to be subject to the similarly sized subscriber group comparison rating methodology.

Medical loss ratio is the portion 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 demonstrate to consumers the value of their premium payments.

In April 2012, OPM issued a final rule establishing an FEHBP-specific MLR requirement for most community-rated FEHBP carriers. The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act and defined by the U.S. Department of Health and Human Services (HHS). The MLR is a financial metric that measures the percentage of premium dollars a health plan spends on medical claims and quality improvements. The remaining percentage should be used to cover the health plan's administrative costs.

The premium rates charged to the FEHBP under the MLR methodology should be developed in accordance with OPM's rules and regulations and the plan's state-filed standard rating methodology. All FEHBP pricing data must be supported by accurate,

complete, and current documentation. A rating methodology is defined as a series of well-defined procedures a carrier follows to determine the rates it will charge to its subscriber groups. An independent professional must be able to follow the carrier's procedures and reach the same conclusion. OPM negotiates benefits and rates with each plan annually and all rate agreements between OPM and the carrier are subject to audit by the OPM OIG. The results of such audits may require modifications to previous agreements and subsequent rate adjustments. Community-rated carriers participating in the FEHBP are subject to various federal, state, and local laws, regulations, and ordinances. In addition, participation in the FEHBP subjects the carriers to the Federal Employees Health Benefits Act and implementing regulations published by OPM.

The following summary represents the notable findings we communicated to Health Net of California regarding its FEHBP premium rate developments.

Audit of FEHBP Operations at Health Net of California, Inc. – Northern and Southern Regions

January 13, 2025 | 2023-CRAG-023

We determined that the Plan did not adhere to the guidance provided in OPM's Benefits Administration Letters and the stipulations in the Code of Federal Regulations (CFR) when terminating its standard option in the Southern and Northern California regions for contract years 2020 and 2021.

Specifically, the Plan's controls surrounding the FEHBP option termination process were insufficient to adequately meet requirements from OPM or the CFR, resulting in enrollees from the standard option not being enrolled in a health plan of their choice during open season or being automatically enrolled in the Plan's basic option. Additionally, we found that the Plan continued to pay standard option network claims for the FEHBP members even though the terminated standard option provider network varied from the basic option provider network and premiums were not paid to the Plan for those members.

The Plan agreed with our recommendation and will provide updated policies and controls upon completion, which will then be passed along to OPM's Contract Benefit Specialist.

Experience-Rated Plans

The FEHBP offers a variety of experience-rated plans, including a service benefit plan, an indemnity 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 60 audit sites, some of which include multiple plans. 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 management, cost accounting, and cash management systems; and
- adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During the current reporting period, we issued three audit reports (not including information security reports) on experience-rated health plans participating in the FEHBP. These reports contained recommendations for the return of more than $8.9 million to the OPM-administered health care trust fund.

Blue Cross Blue Shield Service Benefit Plan Audits

The Blue Cross Blue Shield Association (BCBSA), on behalf of 60 participating health insurance plans offered by 33 Blue Cross and Blue Shield (BCBS) companies, has a governmentwide service benefit plan contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBSA delegates authority to participating local BCBS plans throughout the United States to underwrite and process the health benefit claims of its federal subscribers. Over 67 percent of all FEHBP members are enrolled in the BCBS Service Benefit Plan.

The BCBSA established a Federal Employee Program (FEP) Director's Office in Washington, DC, to provide centralized management of the service benefit plan. The FEP Director's Office coordinates the administration of the contract with the BCBSA, BCBS plans, and OPM.

The BCBSA also established an FEP Operations Center, the activities of which are performed by the service benefit plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, DC. These activities include acting as fiscal intermediary for claims processing between the BCBSA and member plans, verifying subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments for FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining claims payment data.

We issued two BCBS plan audit reports during this reporting period.

Audit of Florida Blue, Jacksonville, Florida

January 8, 2025 | 2024-ERAG-002

Our limited scope audit of the FEHBP operations at Florida Blue covered the Plan's miscellaneous health benefit payments and credits (such as cash receipts and refunds of provider overpayments), administrative expense charges, cash management activities and practices, and carrier fraud and abuse program activities. We questioned $8,466,906 in health benefit charges, net administrative expense overcharges, cash management activities, and lost investment income. We also identified procedural findings for Florida Blue's processing of cash receipt refunds, subrogation recoveries, medical drug rebates, and Special Plan Invoices (SPIs) where funds were not timely returned to the FEHBP during the audit scope. Our most

significant finding was that Florida Blue, because of a lack of due diligence with recovery efforts, had not recovered and/or returned funds totaling $6,792,912 to the FEHBP for 135 claim overpayments. Another significant finding was that Florida Blue had not returned two monthly subrogation recovery amounts, totaling $804,721, to the FEHBP.

Audit of the Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of South Carolina for Contract Years 2020 Through 2022

March 25, 2025 | 2024-CAAG-011

We audited the claims processing and payment operations at Blue Cross and Blue Shield of South Carolina (BCBSSC) to determine if the claims and health benefit payments were made in accordance with applicable contracts and the benefit brochure. Our audit identified two procedural findings.

First, BCBSSC did not follow its internal policies and procedures when adjudicating three claim samples which were deferred because the unlisted procedure code allowances were not in its claims system. In each of these cases, the processors adjudicated the claims to pay at the billed charge and did not receive the required management approval for such reimbursement. Consequently, the errors identified on these claims were not caught and corrected prior to payment. While the specific dollar impact to the FEHBP for this identified issue is minimal, improved policies and procedures will help alleviate the issue and reduce the risk of future FEHBP improper payments.

Second, we found that BCBSSC improperly applied or failed to apply procedure code modifier pricing adjustments for 11 out of 38 claim lines. The errors occurred due to processor errors caused by either a lack of processor training when adjudicating the claim lines or a lack of a focused quality control review process on these types of claims. While the resulting FEHBP overcharges were immaterial, should the high error rate identified in our sample be extrapolated across the universe of approximately 12,500 claim lines, the potential overpayments could be much more significant than what was identified in this audit.

The BCBSA agreed with both findings and is working with BCBSSC to implement corrective actions to address them.

Experience-Rated Comprehensive Medical Plans

We issued one experience-rated comprehensive medical plan audit report during this reporting period.

Audit of HMO Missouri, Inc., Mason, Ohio

March 25, 2025 | 2024-ERAG-004

Our audit of the FEHBP operations at HMO Missouri, Inc., covered health benefit refunds and recoveries, including both pharmacy and medical drug rebates, as well as the Plan's cash management activities and practices related to FEHBP funds.

We questioned $445,502 in health benefit charges, cash management activities, and lost investment income. Additionally, we identified procedural findings related to the processing of cash receipt refunds and pharmacy and medical drug rebates. Our most significant finding was that the Plan, because of a lack of due diligence with recovery efforts, had not recovered and/or returned refunds of $177,662 to the FEHBP. Another significant finding was that the Plan had not returned pharmacy and medical drug rebate amounts totaling $162,373 to the FEHBP.

Oversight of OPM's Implementation of the Postal Service Health Benefits Program

The Postal Service Health Benefits Program (PSHBP) was established within the FEHBP by the Postal Service Reform Act of 2022 (PSRA) (Public Law 117–108), enacted on April 6, 2022, and is administered by OPM's Healthcare and Insurance program office. The PSHBP was created to provide health insurance benefits for U.S. Postal Service employees, annuitants, and eligible dependents beginning on January 1, 2025. For these individuals, eligibility for enrollment or coverage in FEHB health plans ended on December 31, 2024, and enrollment and coverage will only be offered by the Postal Service Health Benefits (PSHB) health plans. Subject to limited exceptions, Postal Service annuitants who retire and become Medicare-eligible after December 31, 2024, and their Medicare-eligible[1] family members, will be required to enroll in Medicare Part B[2] as a condition of eligibility to enroll in the PSHBP. The first open season for the PSHBP began on November 11, 2024, and ran through December 13, 2024. The first contract year began January 1, 2025.

Section 101 of the PSRA added a new section, 8903c, to title 5 United States Code (U.S.C.) 89, which directs OPM to establish the PSHBP. The PSHBP was authorized under the title I Postal Service Financial Reforms provisions in the PSRA in furtherance of Congress's objective to "improve the financial position of the Postal Service while increasing transparency and accountability of the Postal Service's operations, finances, and performance." OPM issued a final rule on May 6, 2024, to set forth standards to implement section 101 of the PSRA to establish the PSHBP.

Our oversight of OPM's implementation of the PSHBP is ongoing, with periodic audits throughout the program implementation. One area of our review was OPM's oversight of the customer support experience related to the PSHBP. The establishment of the PSHBP impacted approximately 1.7 million Postal Service employees, annuitants, and their dependents. Members need customer support related to the new PSHBP,

[1] Medicare is generally for people 65 or older, but may also include people with disabilities, end-stage renal disease, or amyotrophic lateral sclerosis, commonly known as ALS.

[2] Medicare Part B helps cover medical services like doctors' services, outpatient care.

specifically health benefits, such as applying for health benefits, changing health benefits, and accessing the PSHB System. OPM is coordinating with various agencies and organizations to provide customer support. To resolve customer inquiries on the first attempt, the customer support experience focuses on ensuring that all agencies and organizations communicate and transfer calls as needed.

During this reporting period, we issued two interim reports on our oversight of the PSHBP implementation. The following summary represents the notable findings that we communicated to OPM in our report regarding its oversight of the customer support experience for PSHBP.

Audit of OPM's Implementation of the Postal Service Health Benefits Program: Customer Support Experience

October 23, 2024 | PSHB-089

We found that OPM designed a robust customer support experience to be used by all PSHB customers. However, OPM did not have comprehensively documented plans, policies, or procedures for the operation of the customer support experience for the PSHB customers to ensure that each involved agency and organization clearly understood its roles and responsibilities during the PSHBP 2024 open season and thereafter.

Specifically, OPM's Retirement Services contracted with a vendor for its customer service support for Postal Service annuitants and their eligible dependents and to distribute all PSHBP 2024 open season materials to annuitants in a timely manner. The contract includes a task order requiring the vendor to provide the PSHB Helpline, which is managed by OPM's Healthcare and Insurance Office. Additionally, the task order has a Quality Assurance Surveillance Plan (QASP) that outlines the performance standards and acceptable quality levels. The Retirement Services team is also responsible for answering calls related to health insurance enrollment, providing assistance with using the decision support tool, and using a toll-free interactive voice response that sends statistical reports based on the QASP to OPM.

We expressed concern with the low number of specialists on the Retirement Services vendor team providing customer support to PSHB customers. OPM stated that it was not focused on the staffing levels of the vendor but was relying on the terms of the contract and task order to ensure that annuitants received the necessary customer support. Additionally, OPM relied on the results of the QASP to evaluate progress and identify potential issues with the customer service experience administered by the vendor. OPM explained that if the vendor is unable to handle the customer support at the required performance levels, OPM's contingency plan was to leverage resources from OPM's Retirement Services Retirement Information Office and then the Postal Health Benefits Team.

It is essential that OPM has detailed written plans, policies, and procedures to provide customer support, especially during the PSHBP 2024 open season, so that each involved agency and organization clearly

understands its roles and responsibilities. Without such clearly defined documentation, there is a higher risk that customer support would be inadequate to meet demand, particularly during the inaugural open season.

OPM agreed with our recommendation and acknowledged that the plans for a robust customer service experience are continuously evolving.

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems and applications support retirement claims and multiple governmentwide human resources services. Private health insurance carriers participating in the FEHBP rely on information systems and applications to administer health benefits to millions of current and former federal employees and their dependents. And although the Defense Counterintelligence and Security Agency owns the background investigations program, OPM continues to provide support to the legacy background investigations systems.

The ever-increasing frequency and sophistication of cyberattacks on both the private and public sectors make the continual maturation and enhancement of cybersecurity programs a critical need for OPM and its contractors. Information technology audits identify the challenges in responding to the escalating threats to cybersecurity and provide tangible strategies and action plans to rectify and/or mitigate the challenges. The specific audits conducted each year are 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 53 OPM-owned information systems as well as the 64 information systems used by private sector entities that contract with OPM to process federal data.

We issued two information systems audit reports during the reporting period. Those reports are summarized below.

Federal Information Security Modernization Act Audit for Fiscal Year 2024

October 30, 2024 | 2024-ISAG-008

The Federal Information Security Modernization Act (FISMA) inspector general reporting metrics use a maturity model evaluation system derived from the National Institute of Standards and Technology's Cybersecurity Framework. The Cybersecurity Framework is comprised of nine domains , and the weighted averages of the domain scores are used to derive the agency's overall cybersecurity score. For (fiscal year) FY 2024, OPM's cybersecurity maturity level was measured as "3 – Consistently Implemented."

The following sections provide a high-level outline of OPM's performance in each of the nine domains from the five cybersecurity framework functional areas:

Risk Management—OPM has defined an enterprise-wide risk management strategy through its risk management council. OPM has developed and implemented policies, procedures, and processes to maintain an up-to-date inventory of its hardware and software.

Supply Chain Risk Management—OPM has defined and communicated an organization-wide Supply Chain Risk Management (SCRM) strategy that addresses risk appetite and tolerance, strategies and controls, processes for consistently evaluating and monitoring supply chain risk, and approaches for implementing and communicating the SCRM strategy.

Configuration Management—OPM has developed, documented, and disseminated baseline configurations and standard configuration settings for its information systems. The agency has an established configuration change control process. However, the agency has not integrated its overall configuration management plan into its continuous monitoring and risk management programs. OPM has also not established a process to document lessons learned from the implementation of its configuration management activities to make improvements to the plan.

Identity, Credential, and Access Management (ICAM)—OPM provided a comprehensive ICAM strategy and charter detailing its goals and objectives. OPM has enforced multifactor authentication with personal identity verification cards.

Data Protection and Privacy—OPM has established the Office of the Executive Secretariat, Privacy, and Information Management (OESPIM), which has defined and communicated OPM's privacy program plan and related policies and procedures. However, OESPIM has not consistently conducted and maintained system of records notices (SORNs) for all applicable systems. According to OESPIM, the development of a SORN for all applicable OPM systems is currently in progress.

Security Training—OPM has implemented a security training strategy and program. However, a current gap analysis needs to be conducted to demonstrate any weaknesses in specialized training to achieve the Consistently Implemented maturity level within the domain. Additionally, OPM has not provided evidence for how the organization obtains feedback on its security awareness and training information and how that information is used to make improvements.

Information Security Continuous Monitoring—OPM has established information security continuous monitoring policies for its environment. OPM's continuous monitoring strategies address security control monitoring at the organization, business unit, and individual information system levels.

Incident Response—OPM has implemented many of the required controls for incident response. Based upon our audit work, we determined that OPM has successfully implemented all the FISMA

metrics at the level of Managed and Measurable.

Contingency Planning—OPM has implemented several of the FISMA requirements related to contingency planning and continues to improve upon maintaining its contingency plans as well as conducting contingency plan tests on a routine basis.

Audit of the Information Systems General and Application Controls at QualChoice

December 11, 2024 | 2024-ISAG-007

Our audit focused on the claims processing applications used to adjudicate FEHBP claims for QualChoice members, as well as the various processes and information technology systems used to support these applications. Our audit of the information technology security controls determined that QualChoice

- has implemented adequate enterprise security controls.
- has implemented adequate logical access controls.
- could improve its physical access controls.
- has implemented adequate data center controls.
- could improve its network security controls.
- has implemented adequate security event monitoring and incident response controls.
- has implemented adequate configuration management controls.
- has implemented adequate contingency planning controls.
- has implemented adequate system development lifecycle controls.

Internal Audits

Our internal audits focus on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. We conduct comprehensive performance audits and special reviews of OPM programs, operations, and contractors and conduct and oversee certain statutorily required projects for improper payments and charge card reporting. In addition, we oversee OPM's annual financial statement audit, perform risk assessments of OPM programs and operations, and work with program offices to resolve and close internal audit recommendations.

We issued three internal audit reports during this reporting period. Those reports are summarized below.

Audit of OPM's Budget Officer Group

October 7, 2024 | 2023-IAG-025

The Budget Officer Group, within OPM's Office of the Chief Financial Officer (OCFO), is responsible for the execution of budgetary operations necessary to support OPM's programs and personnel. The Budget Officer Group is responsible for performing, advising, and supervising work for all phases of the budget process—formulation, congressional, and execution. This audit

focused on the processes that take place during the execution phase.

The objectives of our audit were to determine if

- the OCFO's Budget Officer Group followed its policies and procedures for the requisition, apportionment and reapportionment, and Interagency Agreement review processes;
- appropriated funds were spent in accordance with applicable laws and guidance; and
- funds for apportionments, requested by program offices were within budget allowances and contract limits.

We determined that the Budget Officer Group effectively supervised all phases of OPM's budget process. Therefore, we did not make any recommendations in this report.

However, we identified two areas of improvement that could have a positive impact on the Budget Officer Group's processes:

- creating written internal policies and procedures for the review and approval of apportionment and reapportionment requests that align with OMB Circular No. A-11, and
- updating the Standard Operating Procedures to include common exceptions to the Interagency Agreement process.

OPM's Consolidated Financial Statements Audits

The Chief Financial Officers Act of 1990 (Public Law 101–576) requires OPM's inspector general or an independent external auditor, as determined by the inspector general, to audit the agency's financial statements in accordance with Government Auditing Standards issued by the Comptroller General of the United States. OPM contracted with KPMG LLP, an independent certified public accounting firm, to audit the consolidated financial statements as of September 30, 2024. The contract required that the audit be performed in accordance with auditing standards generally accepted in the United States, the standards applicable to financial audits contained in Government Auditing Standards, and the OMB Bulletin No. 24-02, Audit Requirements for Federal Financial Statements.

OPM's consolidated financial statements include the agency's Retirement Program, Health Benefits Program, Life Insurance Program, Revolving Fund Programs, and Salaries and Expenses. OPM provides a variety of human resource–related services to other federal agencies, such as pre-employment testing and employee training, and these activities are financed through an intragovernmental revolving fund. Salaries and Expenses provide the budgetary resources used by OPM for the administrative purposes in support of the agency's mission and programs.

KPMG was responsible for, but was not limited to, issuing an audit report that included the following:

- opinions on the consolidated financial statements and the individual statements for the three benefit programs,
- a report on internal control over financial reporting, and
- a report on compliance and other matters.

In connection with the audit contract, we reviewed KPMG's report and related documentation and made inquiries of its representatives regarding the audit. To fulfill our audit responsibilities under the Chief Financial Officers Act for ensuring the quality of the audit work performed, we reviewed KPMG's audit of OPM's FY 2024 consolidated financial statements in accordance with Government Auditing Standards. Specifically, we

- provided oversight, technical advice, and liaison to KPMG auditors;
- ensured that audits and audit reports were completed timely and in accordance with the requirements of generally accepted government auditing standards (GAGAS), OMB Bulletin 24-02, and other applicable professional auditing standards;
- documented oversight activities and monitored audit status;
- reviewed responses to audit reports per OMB Circular No. A-50, Audit Follow-up;
- coordinated issuance of the audit report; and
- performed other procedures we deemed necessary.

Our review disclosed no instances where KPMG did not comply in all material respects with GAGAS.

Audit of OPM's Fiscal Year 2024 Consolidated Financial Statements

November 15, 2024 | 2024-IAG-017

KPMG LLP reported on its financial statement audit of OPM's consolidated financial statements, which comprise the

- consolidated balance sheet as of September 30, 2024,
- related consolidated statements of net costs and changes in net position,
- combined statement of budgetary resources for the year then ended, and
- related notes to the consolidated financial statements.

KPMG's report also covers the financial statements of OPM's Retirement Program, Health Benefits Programs, and Life Insurance Program, which comprise the balance sheets as of September 30, 2024, and the related statements of net cost, changes in net position, and statements of budgetary resources for the years then ended, presented in the accompanying consolidating and combining financial statements, and the related notes to the financial statements.

KPMG reported the following:

- The consolidated financial statements present fairly, in all material respects, the financial position of OPM as of September 30, 2024, and its net cost, changes in net position, and budgetary resources for the year then ended in accordance with U.S. generally accepted accounting principles.
- The financial statements present fairly, in all material respects, the financial position of the Retirement Program, Health Benefits Program, and Life Insurance Program as of September 30, 2024, and their respective net costs, changes in net position, and budgetary resources for the year then ended in accordance with U.S. generally accepted accounting principles.

KPMG's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

KPMG did not identify any material weakness; however, they did identify one significant deficiency in OPM's internal control related to improvements needed in controls over information technology.

Improvements Needed in Controls over Information Technology—In FY 2024, OPM management made progress on remediation efforts of prior year control deficiencies in information technology general controls. However, key corrective actions to fully address previously identified information system deficiencies were not completed as of September 30, 2024. The information technology controls were not consistently designed, implemented, or operating effectively to protect three primary source systems supporting OPM's benefits programs, including the system used in the calculation of retirement payments, the system used to record and issue payments for initial retirement and recurring annuities, and the system used to receive and record revenue from employee withholdings and employer contributions. OPM was pleased to have the long-standing information technology material weakness downgraded to the significant deficiency. OPM concurred with the audit recommendations and remains committed to making continuous improvements to the internal control environment.

The results of KPMG's tests of OPM's compliance with certain provisions referred to in section 803(a) of the Federal Financial

Management Improvement Act of 1996 disclosed no instances in which OPM's financial management systems did not substantially comply with the (1) federal financial management systems requirements, (2) applicable federal accounting standards, and (3) the U.S. Government Standard General Ledger at the transaction level.

Audit of OPM's Audit Resolution Process

November 26, 2024 | 2023-IAG-021

OMB Circular No. A-50 Revised[3] requires that federal agencies establish systems to assure prompt resolution and corrective actions on audit recommendations. Responsibilities are assigned to various levels of management to ensure that the objectives of OMB Circular No. A-50 Revised are accomplished. Agency heads are responsible for designating a top management official to oversee audit follow up, including resolution and corrective actions, and for ensuring that management officials throughout the agency understand the values of the audit process and are responsive to audit recommendations. Agency management officials are responsible for receiving and analyzing audit reports, providing timely responses to the audit organization, and taking corrective actions where appropriate. Where management officials disagree with an audit recommendation, the matter will be resolved by a higher-level management official or by the audit follow-up official.

OPM's audit resolution process is handled by Internal Oversight and Compliance (IOC) and Audit Resolution and Compliance (ARC).

IOC coordinates activities to resolve recommendations addressed to OPM and/or program offices within OPM. These recommendations are issued by the OPM OIG, as well as other federal agencies, including the U.S. Government Accountability Office and National Archives and Records Administration.

ARC is responsible for working with the Federal Employee Insurance Operations' Contracting Officers to resolve the OIG's recommendations issued to the FEHBP carriers and other contractors providing benefits to federal employees, such as the Federal Employees' Group Life Insurance (FEGLI), Federal Employees Dental and Vision Insurance (FEDVIP), Federal Flexible Spending Account (FSAFEDS), and Federal Long Term Care Insurance (FLTCIP) Programs.

The objectives of our audit were to determine if

- OPM is following applicable laws, regulations, and internal policies and procedures to resolve open recommendations.
- OPM is monitoring the resolution process to ensure that an agreement on the corrective action occurs within a maximum of 6 months from the issuance of the final report and that the

[3] OMB Circular No. A-50 Revised was the criteria in place during our audit and has now been rescinded and replaced with the revised OMB Circular A-50, M-25-01, dated November 7, 2024.

implementation of resolved recommendations is timely.

- monetary recoveries that should be returned to OPM, in comparison to the amount of questioned costs from the OIG's reports, are appropriate and received.
- segregation of duties exists within OPM's audit resolution process between parties responsible for administering OPM's programs and those responsible for resolving findings and recommendations identified in the OIG's reports.

Our audit found that

- OPM lacks an enterprise-wide structure for its audit resolution process.
- OPM uses two different program offices, ARC and IOC, to conduct audit resolution activities with varying processes and no uniform system to manage resolution activities.
- The ARC and IOC offices are not consistently following applicable laws, regulations, or internal policies and procedures.
- IOC did not ensure that resolution documentation was maintained and/or readily available. OPM could not demonstrate that its audit follow-up official is ensuring that audit follow-up, resolution, and corrective actions are documented and in place.
- Memoranda of Understanding are outdated and not aligned with current audit resolution processes.
- Neither ARC nor IOC resolved all recommendations within 6 months after the issuance of the final report or completed final action on each management decision required with regard to recommendations within 12 months after the date of the final report, as required by OMB Circular No. A-50 Revised and the Inspector General Act of 1978, as amended.
- The ARC and IOC offices are not ensuring that monetary recoveries are properly tracked and returned to OPM's programs.
- While segregation of duties exists between ARC and IOC, their lack of communication with one another has led to inefficiencies in their audit resolution processes.
- ARC did not ensure that OPM's audit follow-up official was responsible for resolving recommendations for two health carrier audits.

Special Audits

In addition to health insurance and retirement programs, we audit various other benefit programs administered by OPM for federal employees, annuitants, and their eligible dependents. These include the FEGLI, FSAFEDS, FLTCIP, and FEDVIP Programs.

Our audits of the Combined Federal Campaign (CFC) ensure monies donated by federal employees and annuitants are properly handled and disbursed to charities according to the designations of contributing employees and annuitants.

We also conduct audits of pharmacy benefit managers (PBMs) that administer pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure costs charged and services provided to federal subscribers are in accordance with the contracts and applicable federal regulations.

We issued one special audit report during this reporting period. The report is summarized below.

Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2017 Through 2022

November 14, 2024 | 2023-SAG-019

We conducted a performance audit of Compass Rose Health Plan's Pharmacy Operations as administered by Express Scripts, Inc., a PBM. The objective of this audit was to determine whether costs charged to the FEHBP and services provided to its members were in accordance with OPM Contract Number CS 1065 and applicable federal regulations. Our audit included a review of the administrative fees, annual accounting statements, claims eligibility and pricing, drug manufacturer rebates, fraud and abuse program, and performance guarantees for FEHBP pharmacy operations during contract years 2017 through 2022.

We found that Express Scripts overcharged Compass Rose and the FEHBP $18,443,118, including lost investment income, by not passing through all discounts and credits related to prescription drug pricing as required under the PBM transparency standards found in the Compass Rose contract with OPM. Specifically, our audit identified four findings that require corrective action. The findings occurred throughout all years of the audit scope unless otherwise noted:

- The FEHBP did not receive pass-through transparent drug pricing from the Express Scripts for retail pharmacy claims, resulting in a $6,555,372 overcharge.
- Express Scripts failed to return $1,045,333 in retail pharmacy claim transaction fees credited for the Compass Rose retail prescription drug benefits.
- The FEHBP did not receive several of the drug purchasing discounts collected by Express Scripts for drugs filled by its own mail-order warehouses and specialty pharmacies, resulting in a $248,194 overcharge.
- Express Scripts' sister company, Ascent Health Services, erroneously withheld a portion of the FEHBP's drug manufacturer rebates from June 2019 through December 2021, resulting in $10,594,219 due to the Compass Rose and FEHBP.

No exceptions were identified from our reviews of administrative fees, annual accounting statements, claims eligibility, fraud and abuse program, and performance guarantees.

Evaluation Activities

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

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

Enforcement Activities

The OPM OIG conducts vital law enforcement activities as part of our oversight operations and to fight fraud, waste, and abuse in OPM programs. The Office of Investigations' criminal, civil, and administrative investigative efforts and our Administrative Sanctions Group's (ASG) debarments and suspensions are essential to protecting OPM program users and the American people.

Investigative Activities

The OPM OIG Office of Investigations investigates fraud, waste, and abuse in OPM programs and operations. Our criminal, civil, and administrative investigations protect the public, federal employees, annuitants, and their eligible family members. In this section, we present a summary of our investigative efforts and discusses challenges to our law enforcement oversight mission.

We are a nationwide law enforcement organization conducting investigations to safeguard the financial and program integrity of the Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), FEHB, PSHB, FEDVIP, and FEGLI programs. Millions of current and retired federal civilian employees and their eligible family members receive benefits through OPM programs. Our investigative actions return fraudulently earned or wasted money to the government. This offsets future health insurance premium increases, protects the retirement program trust fund, and prevents the further waste of taxpayer dollars. In this reporting period, we secured investigative outcomes that returned or will return more than $2.7 million to OPM programs. We also participated in investigations with our law enforcement partners, such as the Federal Bureau of Investigation (FBI) or HHS OIG, that overall returned $347 million to the federal government.

The Office of Investigations pursues its oversight of OPM programs and operations guided by three investigative priorities:

- investigations of physical or financial harm to OPM program users
- investigations of substantial program financial losses from fraud, waste, or abuse
- investigations of program vulnerabilities or employee or contractor misconduct, fraud, waste, or abuse

The cases herein illustrate the reach of our law enforcement efforts, which are important to protecting civil servants, retirees, and eligible family members from fraud, waste, and abuse and recovering taxpayer dollars on behalf of the American public.

Health Care Fraud Investigations

Health care fraud investigations comprise the largest share of the OPM OIG's investigative portfolio. These cases are the likeliest to directly harm Americans and have the biggest taxpayer cost through the financial losses to OPM programs.

In our health care fraud investigations, OPM OIG criminal investigators and investigative staff review complex health care claims and records to parse valid claims from fraudulent ones. Our criminal investigators conduct investigatory interviews with patients and health care professionals, perform field investigative work such as surveillance, and execute search and arrest warrants. Our nationwide law enforcement operations work with federal law enforcement partners at the FBI and other OIGs as well as state and local law enforcement, including participation on health care fraud taskforces and nationwide takedown operations.

In this semiannual report, we highlight health care fraud investigations involving a genomic testing scam; a consulting company that contributed to the rampant opioid crisis by advising drug companies how to illegally and improperly market addictive opioids; and a chain of supermarket pharmacies that allegedly recklessly distributed opioids in violation of the False Claims Act.

OPM OIG Data Warehouse Supports Health Care Investigations

The OPM OIG uses its data warehouse as part of developing its health care fraud investigations. The ability to find initial claims data and determine FEHBP fraud exposure through the data warehouse often is the baseline for determining whether we will pursue an allegation further. The data warehouse is particularly valuable for pharmaceutical claims data, which continues to be a growing area of costs to the FEHBP overall. Our Office of Investigations works with the OPM OIG Data Management Group to use the data warehouse's information to identify and investigate fraud, waste, and abuse.

Genomic Breast Cancer Testing Fraud Scheme Costs the FEHBP $1.9 Million

Three settlements finalized in January 2025 resolved alleged violations of the False Claims Act by an oncology testing company, a dermatopathology lab, and a radiology practice and put an end to a scheme involving unnecessary genomic breast cancer testing.

In November 2021, we received a qui tam[4] filed in the U.S. District Court for the Eastern District of Tennessee alleging that an oncology testing company submitted false genomic testing claims for reimbursement. As part of the scheme, a Tennessee dermatopathology lab entered into arrangements with radiology clinics to have the genomic test sent to the laboratory, regardless of whether the patient needed the test.

Between January 2019 and January 2023, the FEHBP paid $1.9 million for nearly 1,000 genomic testing claims.

The laboratory also paid medical providers to encourage them to order the genomic

[4] The False Claims Act allows private citizens to file suits on behalf of the United States against those who have defrauded the government. These suits are called "qui tam" suits. Private citizens who successfully bring qui tam actions may receive a portion of the government's recovery.

tests. Extravagant dinners, excessive honoraria payments, gift cards, and even a $1,000-per-month contractor arrangement were part of the scheme to increase the number of genomic test claims sent to the laboratory.

The oncology testing company entered into a $10 million settlement agreement with the government to resolve allegations that it violated the False Claims Act.

A radiology company that was part of the scheme entered into a $322,500 settlement agreement with the government to resolve allegations that it violated the False Claims Act.

The dermatopathology laboratory entered into a $207,500 settlement agreement with the government to resolve allegations that it violated the False Claims Act.

The OPM OIG recovered a total of $590,244 from these three settlements. The OPM OIG was not included in any settlement calculations related to the laboratory claims tainted by the alleged illegal kickbacks because the FEHBP is excluded from the Anti-Kickback Statute.

The FEHBP is excluded from the Anti-Kickback Statute (42 U.S.C. §§ 1320a–7b), which makes it illegal for health care providers to knowingly and willfully accept bribes or other forms of remuneration in return for activities such as patient referrals. The FEHBP's exclusion can, like in this case, interfere with our ability to fully protect the FEHBP, its members, and taxpayer dollars from improper conduct that would constitute a federal crime when committed against any other federally funded health care program. The OPM OIG continues to work with Congress to advance reforms that would allow our office to pursue restitution for anti-kickback violations and recover related fraudulent payments, with the goal of upholding the integrity of the FEHBP and ensuring the safety of its members.

Investigative Priority: The Opioid Epidemic

President Donald J. Trump declared the opioid epidemic a Public Health Emergency in 2017, and HHS most recently renewed the declaration on March 18, 2025. Executive agencies across the government, including OPM, have devoted resources to stopping those whose actions worsen the crisis. The OPM OIG protects the American public by investigating those who recklessly contribute to opioid addiction or misuse. The OPM OIG uses its investigative resources to combat the opioid crisis at all levels, from irresponsible pharmaceutical companies to dangerous pill mills to abusive sober homes and treatment centers.

Consulting Firm Settles for $650 Million Over Consulting Work for Opioid Manufacturer

We joined a case with the FBI's Health Care Fraud Task Force investigating a consulting firm that provided services for multiple opioid drug makers that allegedly increased opioid sales.

The allegations included the consulting firm recommending that one drug company focus on selling lucrative high-dose opioids (even after that company pleaded guilty to criminal charges in 2007 to misbranding an opioid pain medication) and attempting to

help another drug company keep patients on opioids for even longer, which could contribute to addiction. The alleged actions of the consulting firm may have contributed indirectly to overdose deaths and the opioid crisis.

Our investigative staff identified $277 million paid by the FEHBP between January 2009 and December 2016 for just four opioid drugs made by the companies that received consulting services from the subject of our investigation. OPM OIG investigative staff conducted interviews and performed document reviews, including reviewing hundreds of pages of corporate papers to uncover the extent of the consulting company's involvement in helping pharmaceutical companies inappropriately market opioids.

The consulting firm and the government agreed to a $650 million settlement to resolve criminal and civil investigations into the firm's opioid consulting work, and from this settlement $1.2 million will be returned to the FEHBP. The agreement also included a 5-year deferred prosecution agreement on one felony count of knowingly destroying records with the intent to impede, obstruct, and influence the investigation and one misdemeanor count of conspiring to aid and abet the misbranding of prescription drugs.

The consulting firm will also implement a compliance program and refrain from doing any work related to the marketing, sale, promotion, or distribution of controlled substances during the 5-year deferred prosecution agreement.

One individual was also charged by criminal information in the U.S. District Court for the Western District of Virginia with obstruction of justice for allegedly destroying or concealing records. We expect further judicial action related to this criminal information.

Supermarket Pharmacies Allegedly Violated the False Claims Act in Opioid Dispensing

In June 2024, the U.S. Attorney's Office in the District of Tennessee sent the OPM OIG a request for information about controlled substance prescriptions filled by a supermarket chain's pharmacies because the supermarket was the subject of a qui tam that alleged the pharmacies violated the False Claims Act by dispensing controlled substances, including opioids, without a valid prescription or when not medically necessary or with legitimate medical purpose.

Our investigative staff identified relevant claims data that fit the allegation criteria. Between January 2011 and December 2018, FEHBP health insurance carriers paid $1,046,081 in claims related to the allegations. The prescriptions inappropriately filled included opioids.

The supermarket and the government agreed to a settlement to resolve the allegations that the supermarket violated the False Claims Act. On December 3, 2024, the $8.4 million settlement, with $4.24 million in accrued interest, became final. The FEHBP will receive $396,736.

Retirement Fraud Investigations

OPM retirement programs (FERS and CSRS) pay annuities to retired civil servants and survivor annuitants, as well as some disabled children of deceased annuitants.

The OPM OIG investigates a variety of fraud schemes that target retired OPM annuitants and survivor annuitants or the retirement program's financial integrity.

OPM retirement programs are also a target of criminals who engage in financial elder abuse. The perpetrators are sometimes those people the annuitants trust most: caretakers, court-appointed Representative Payees, or even family. It is an OPM OIG priority to investigate cases of alleged harm, including elder financial abuse, to annuitants or survivor annuitants.

Our criminal investigators' efforts often expose deceptive and fraudulent actions that perpetrators use to hide the discovery of their crimes, such as forging responses to OPM's Address Verification Letters or, as described in a case below, opening bank accounts under the name of a deceased annuitant. Improper annuities can continue for years and cost tens of thousands of dollars in taxpayer funds because of these schemes.

Grandson Sentenced for Stealing $120,000 Annuity

A grandson admitted to OPM OIG criminal investigators that he pocketed more than $120,000 in annuity and survivor annuity payments stolen after his grandmother's death.

OPM's Retirement Services sent a case referral regarding a person who continued receiving both an annuity and survivor annuity until August 2019 despite their November 2016 death.

OPM made $78,926 in annuity payments and $144,141 in survivor annuity payments to the decedent. After OPM recovered $21,177 through reclamation actions with the U.S. Department of the Treasury, the net fraudulent payment was $201,297.

Our investigation uncovered that the decedent's son and grandson both had access to and stole annuity payments. The son had died in December 2017, but the grandson still had access to the annuity payments and continued to pilfer government funds.

Our investigation centered on the $128,033 in OPM annuity payments and an additional $11,463 in Social Security payments that we could prove the grandson had access to after both the annuitant and her son died.

During an interview with OPM OIG criminal investigators, the grandson confessed to using the annuity and knowing that the money was government funds he was not entitled to. When surveilling the subject prior to executing the arrest warrant, an OPM OIG law enforcement officer realized that the grandson had moved. Our law enforcement officer was able to track the individual to their new residence, and OPM OIG special agents with our federal and state law enforcement partners safely conducted the arrest operation.

In July 2024, the grandson was indicted by a grand jury in the U.S. District Court for the Middle District of Florida on two counts of theft of government funds. On October 7, 2024, he pleaded guilty to one count of theft of government funds. On January 6, 2025, he was sentenced to 6 months of community confinement (also known as a halfway house) and 3 years of probation. The court also ordered the grandson to pay restitution of $139,497, including $128,033 to OPM.

Annuitant's Daughter Agrees to Consent Judgment to Return Stolen Government Annuity

As part of a consent judgment that returned $153,229 in stolen money to the government, including $71,453 to OPM, a deceased annuitant's daughter admitted she did not inform federal agencies of her mother's death and misappropriated funds from multiple federal agencies.

We received information in June 2019 from OPM's Retirement Services program office that an annuitant's August 2014 death went unreported to the agency. Retirement Services initially calculated the overpayment as $77,173, but after recovering money through reclamation actions, the remaining improper payment was $74,044.

Our investigation uncovered detailed financial information showing that the deceased annuitant's daughter had access to the annuity payments through a shared bank account. We presented this information and the case to the U.S. Attorney's Office for the Southern District of New York, where the Civil Division accepted the case. In March 2023, the Assistant U.S. Attorney for the Southern District of New York filed a civil complaint against the daughter for $153,229 for the misappropriated funds from the various government agencies, including OPM.

The OPM OIG's $71,453 civil recovery is an example of one of the ways our investigations return taxpayer dollars to the American people.

State Law Enforcement Collaboration Leads to Guilty Plea Over Identity Theft and Stolen Survivor Annuity

We collaborated with one of our state law enforcement partners on a case that involved a survivor annuitant's stepdaughter stealing annuity payments through identity theft. The survivor annuitant had dementia and had lived in a care facility since 2018.

In January 2024, we received a request for assistance from the Suffolk County, New York, District Attorney's Office with an ongoing investigation into misdirected pension checks and information from Suffolk County Adult Protective Services. The survivor annuitant's appointed legal guardian had found discrepancies in the survivor annuitant's financial records.

The survivor annuitant died just days after we received the request for assistance.

Our investigative team provided the survivor annuitant's financial information and annuity payment records. These records showed that the stepdaughter used the survivor annuitant's identity to open a bank

account and misdirect $47,327 from the annuity. The bank where the account was opened was able to reimburse the survivor annuitant prior to her death.

On January 29, 2025, the stepdaughter pleaded guilty to grand larceny in the fourth degree. On March 26, 2025, according to the terms of the plea agreement, the stepdaughter was sentenced to 5 years of probation and ordered by the court to pay $31,515 in restitution to the bank where she opened the account that she used in the fraud.

The OPM OIG works with state law enforcement partners to protect OPM annuitants and survivor annuitants from fraud, elder abuse, and other harms, and encourages state law enforcement to reach out to OPM for assistance if OPM annuitants are the victims of a crime related to the theft of their annuity or financial elder abuse.

The OPM OIG's Use of the Treasury Do Not Pay Portal

In FY 2024, the OPM OIG received access to the Department of the Treasury's Do Not Pay (DNP) portal. Access to this system allows our investigative staff to use the robust death data available via the portal to compare the OPM annuity rolls with the death sources in the DNP system and perform searches for deceased annuitants and survivor annuitants. Thus far, we have found 1,200 annuitant records and more than $15 million in annual annuities for the OPM OIG to review for potential investigation and action. Our investigative work using this data is ongoing but has already identified $1.6 million in payments to deceased annuitants and recovered $421,271.

Investigations involving information from the DNP portal can result in criminal or civil investigations or administrative recoveries. We highlight one of our proactive efforts that led to the recovery of $87,000 during this reporting period. As our work using the DNP portal continues, we will report additional recoveries and investigations generated by our investigative staff using the DNP portal.

Proactive Findings from OPM OIG Do Not Pay Project Returns $87,000

The OPM OIG has an ongoing proactive project to identify deceased annuitants by matching agency information with Treasury's DNP Death Data Sources. In May 2024, the OPM Retirement Services Fraud Branch provided the OPM OIG with records from the annuity roll match with Treasury's DNP data. In our analysis of the records that OPM's Retirement Services could not verify, our investigative analysts identified an annuitant who died but was continuing to be sent an annuity. We contacted our law enforcement partner at the U.S. Social Security Administration OIG with the annuitant information from the DNP portal, and our partner shared that they had information showing the annuitant died in March 2021.

The decedent had been sent annuities totaling $87,585 after his death.

Based on the shared information, we notified Retirement Services of the annuitant's death and requested they stop issuing annuity payments for death. This allowed OPM to pursue Treasury reclamation actions. OPM recovered the full amount of the improper payment on October 29, 2024.

Integrity Investigations

The OPM OIG investigates allegations of fraud, waste, abuse, or misconduct by OPM employees and contractors. The investigations we conduct are essential to keeping the trust of the American public and ensuring the agency's appropriate stewardship of OPM programs and operations.

During this reporting period, we do not have any publicly reportable results from criminal, civil, or administrative investigations into OPM employees, contractors, or programs.

The OPM OIG Hotline

The OPM OIG receives allegations of fraud, waste, or abuse affecting OPM programs and operations through its OPM OIG hotline. Hotline contacts are incredibly important sources for our investigations. The OPM OIG hotline is only for information related to OPM programs and operations.

Lifecycle of Fraud, Waste, and Abuse Investigative Recoveries

The OPM OIG investigative process begins when we receive a fraud, waste, or abuse allegation from a source—such as information from other OPM OIG components, FEHBP health insurance carriers or referrals from OPM program offices, whistleblowers, federal and state law enforcement partners, or the OPM OIG hotline—or we develop a case based on our proactive efforts. We first perform data analysis and focused investigative activities when our investigative analysts and other investigative staff determine whether there is a risk of harm to individuals and to quantify the fraud, waste, and abuse amount that the allegations potentially cost OPM programs. In some cases, the potential loss is provided by FEHBP health insurance carriers and OPM OIG investigative analysts look for similar fraud across the other health insurance carriers. In this reporting period, FEHBP health insurance carriers referred $208 million in potential fraud to the OPM OIG for further investigative action.

When our investigative analysts and criminal investigators consider these referrals, we look for the relevance of the allegations to OPM programs, the loss amount, and other factors that determine whether the OPM OIG will expend any of its finite investigative resources to pursue an investigation. The Statistical Summary of Enforcement Activities shows the number of our cases in the various stages of our investigative work. Investigations, from the time the allegation is received to final disposition, can take months or years to resolve depending on the complexity of the investigation and other circumstances.

Investigations that find fraud, waste, and abuse are presented to the U.S. Department of Justice's various U.S. Attorney's Offices (or state-level prosecutor offices) for

potential action. The U.S. Department of Justice ultimately makes the decision whether to pursue criminal or civil action based on the facts of our investigation. In this reporting period, we presented potential fraud, waste, and abuse allegations totaling more than $72 million.

Our investigative and law enforcement actions are essential to the return of millions of dollars to OPM programs. In this semiannual period, the real dollars returned to OPM trust funds—that is, the actual money confirmed as received by the OPM OCFO—was approximately $2.5 million. These amounts may be from settlements, payment plans for restitution orders, or other financial arrangements between OPM or the U.S. Department of Justice and the subjects of our investigative efforts.

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 insufficient professional responsibility to participate in the FEHBP. At the end of the reporting period, there were a total of 39,982 active suspensions and debarments which prevented health care providers from participating in the FEHBP.

Debarment disqualifies a health care provider from receiving payment of FEHBP funds for a stated time period. The FEHBP has 18 bases for debarment. The most frequently cited provisions are for criminal convictions or professional licensure restrictions/revocations. Before debarring a provider, our office gives the provider notice and the opportunity to contest the sanction in an administrative proceeding.

Suspension has the same effect as a debarment, but it becomes effective upon issuance without prior notice and remains in effect for a limited time. The 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.

During the reporting period, we issued 520 administrative sanctions (including both suspensions and debarments) of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we addressed 1,863 sanctions-related inquiries and correspondence.

We develop our administrative sanctions caseload from a variety of sources, including the following:

- administrative actions issued against health care providers by other federal agencies
- cases referred by the OPM OIG Office of Investigations
- cases identified by the OPM OIG ASG through systematic research and analysis of electronically available information about health care providers
- referrals from other sources, including health insurance carriers, state regulatory entities, and federal law enforcement agencies

Administrative sanctions serve two important functions. First, they protect the

financial integrity of the FEHBP. Second, they protect the health and safety of federal employees and annuitants and their eligible family members who obtain their health insurance coverage through the FEHBP.

The following cases handled during the reporting period highlight the importance of our proactive work identifying cases.

Suspension of a New Mexico Occupational Therapist Indicted for Sexual Assault of Minors, Practicing Without a License, and Battery

In January 2025, our office suspended an occupational therapist in New Mexico who was indicted for criminal activities related to minor children, practicing without a medical license, and battery.

In a July 2024 indictment filed in New Mexico's Ninth Judicial District Court, the occupational therapist was charged with one count of Criminal Sexual Penetration of a Minor (Child under 13), five counts of Criminal Sexual Contact (Child under 13), three counts of Practicing Without a License, and one count of Battery.

According to the indictment, between December 2023 and April 2024, the occupational therapist practiced medicine or attempted to practice medicine on children under the age of 13 without first complying with the Medical Practice Act and without being the holder of a license entitling him to practice medicine in the state of New Mexico.

In addition, referrals to the occupational therapist were made by local pediatricians and day care centers. However, the occupational therapist failed to submit his evaluations to the pediatricians. He also violated the standard of care for an occupational therapist.

Alaskan Physician and His Clinic Debarred for Health Care Fraud Involving Illegal Distribution of Scheduled Controlled Substances

In October 2024, we debarred a physician and his clinic after he pleaded guilty in the United States District Court for the District of Alaska to a violation of 21 U.S.C. § 841(a)(1), distribution of a scheduled controlled substance. Court documents allege that the physician conspired with a colleague to illegally distribute large amounts of opioids and other powerful narcotics by writing prescriptions for patients without medical examinations and with no medical necessity.

The physician owned and practiced at his clinic in Soldotna, Alaska. The criminal complaint charged him with illegally distributing controlled substances outside the course of professional practice. According to court documents he prescribed over 700,000 narcotic pills between 2017 and 2019. During that time, the leading medications prescribed included hydrocodone, oxycodone, morphine, methadone, and tramadol. Drug abusers on the Kenai Peninsula referred to him as the "Candy Man" because it was common knowledge that people could obtain pain medication prescriptions from him even though they did not have a legitimate medical need. Law enforcement agencies

continue to investigate the physician's prescribing history.

In January 2023, he pleaded guilty of knowingly distributing oxycodone in a way that was "outside the usual course of professional practice and without a legitimate medical purpose." In July 2023, he was sentenced to 12 months of probation and fined $1,100 dollars. A debarment period of 3 years was given to the physician and the clinic he owned. This case was referred to us by BCBS.

Pennsylvania Nurse Practitioner Debarred After Permanent Surrender of License

In October 2024, our office debarred a nurse practitioner after the Pennsylvania's State Board of Nursing accepted the permanent surrender of his license for actions that were deemed unprofessional and presented a risk to the public after he was arrested and charged with one count of Theft by Deception, one count of Insurance Fraud, and one count of Procuring for Self/Other Drug by Fraud.

The Pennsylvania Attorney General's Office filed felony charges against the nurse practitioner after he tried to fraudulently obtain a prescription for oxycodone from a CVS Pharmacy in Clarion, Pennsylvania. An investigation was initiated after a pharmacy manager contacted a special agent from the Attorney General's office to report the suspicious activity.

According to the Special Investigations Unit Investigative Report included in the referral from BCBS, the pharmacy manager reported that a staff pharmacist received a voicemail from the nurse practitioner inquiring about 240 10mg Percocet tablets for a patient (later identified as the nurse practitioner's girlfriend). The pharmacist informed the nurse practitioner that a prescription of that quantity could not be filled if the patient in question had never received opiate medications.

Later on the same day, a Veterans Administration Medical Clinic (VAMC) pharmacy received a faxed letterhead prescription for a lower quantity, 60 Percocet 10mg tablets, for a patient that was recovering from surgery. The faxed prescription included the nurse practitioner's contact information; however, the document was unsigned and did not contain his U.S. Drug Enforcement Administration registration number, medical license number, National Provider Identifier, or other information required for a valid prescription. In addition, the pharmacy received a hard copy prescription on a Veterans Administration Security Prescription Form, which indicated the prescription was to be 240 tablets of Percocet 10mg from the facility. The staff pharmacist contacted the patient (i.e., the nurse practitioner's girlfriend) and informed her that the prescription would not be filled until it was verified.

The pharmacy manager contacted the VAMC regarding the prescription. A VAMC employee confirmed the person was not a patient at the Veterans Administration and was not undergoing treatment by the nurse practitioner. The employee also noted that the nurse practitioner was on medical leave when he submitted the prescriptions. The

nurse practitioner submitted false information to obtain Schedule II Drugs which resulted in the permanent revocation of his license. Our office debarred the nurse practitioner for an indefinite period based on the revocation of his license. This case was referred to us by BCBS.

Debarment of Two Texas Medical Practices Based on Affiliation with a Debarred Physician

In May 2024, our office debarred a Texas physician based on his exclusion by the HHS for a conviction related to patient abuse or neglect, which carries a minimum 5-year exclusion period. His debarment runs concurrently with the term of his HHS exclusion. As of March 2025, our debarment and his HHS exclusion remain in effect.

OPM debarments prohibit health care providers from participating in the FEHBP, which provides health insurance coverage to federal employees, annuitants, and their immediate family members (FEHBP enrollees). Debarred providers cannot receive payment of FEHBP funds, either directly or indirectly, for services or supplies furnished, such as written prescriptions, to any person enrolled in one of the FEHBP's health insurance plans.

In August 2024, the BCBSA notified our office that they received a claim for a prescription written by the debarred provider and presented by an FEHBP enrollee for fulfillment after the effective date of the provider's debarment. As a result, in December 2024, we issued a "shock and alarm" notice to the debarred physician reminding him that his OPM debarment prohibits him from participating in the FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. We informed the physician that his actions were violations of his debarment terms and, should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the federal false claims statutes and potentially result in prosecution. Additionally, the physician was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

The physician's violation of his debarment terms prompted our ASG to investigate the entities with which the debarred provider was affiliated. The investigation revealed that the debarred physician owned/controlled two medical practices.

The debarred physician's actions and affiliation with the medical practices posed a risk to FEHBP enrollees and the financial integrity of the program. Therefore, in February 2025, we issued notices proposing the debarment of the two medical practices.

The debarments of the medical practices went into effect in March 2025, and will coincide with the debarment terms of the debarred physician.

Ohio Dental Clinic Debarred Based on Cancellation of State License and Ownership by Debarred Dentist

In November 2021, our office debarred an Ohio dentist based on his exclusion by HHS for program-related crimes, which carries a 5-year exclusion period. His debarment runs concurrently with the term of his HHS exclusion. As of March 2025, our debarment and his HHS exclusion remain in effect.

Debarred providers cannot receive payment of FEHBP funds, either directly or indirectly, for services or supplies furnished, such as written prescriptions, to any person enrolled in one of the FEHBP's health insurance plans.

The National Association of Letter Carriers (NALC) notified our office that they received a claim for a prescription written by the debarred provider and presented by an FEHBP enrollee for fulfillment after the effective date of the provider's debarment. As a result, we issued a "shock and alarm" notice to the debarred dentist reminding him that his OPM debarment prohibits him from participating in FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. We informed the dentist that his actions were violations of his debarment terms and, should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the federal false claims statutes and potentially result in federal prosecution. Additionally, the dentist was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

The dentist's violation of his debarment terms prompted the ASG to investigate the entities with which the debarred provider was affiliated. Our research revealed the debarred provider owned a dental clinic. Additionally, the dental clinic's license was cancelled by the State of Ohio in August 2024, for not filing its biennial report. As a result, in February 2025, we issued a notice of proposed debarment to the dental clinic.

The debarment of the dental clinic went into effect on March 20, 2025, and will coincide with the period in which its business license is revoked, suspended, restricted, or otherwise not in effect.

Texas Physician Violates Terms of Debarment, Resulting in Pre-Debarment Notifications to Two Medical Facilities

In December 2018, our office debarred a Texas physician based on his November 2018, exclusion by HHS for a conviction for health care related crimes which carries a minimum of a 5-year exclusion period. His debarment runs concurrently with the term of his HHS exclusion. As of March 2025, our debarment and his HHS exclusion remain in effect.

BCBS and the NALC notified our office that a debarred physician caused the submission of pharmacy claims to FEHBP health insurance carriers for prescriptions written to FEHBP enrollees after the effective date of his debarment. BCBS reported that approximately 309 prescriptions written by the debarred physician were presented for

fulfillment between January 2023, and July 2024, and NALC reported that 2 prescriptions written by the debarred physician were presented for fulfillment in September 2024.

In December 2024, the ASG issued a "shock and alarm" notice to the debarred physician informing him that his actions were violations of his debarment terms, and should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the federal false claims statutes and potentially result in federal prosecution. Additionally, the debarred physician was informed that such claims may be a basis for the OPM OIG Debarring Official to deny or delay future reinstatement into the FEHBP.

The physician's violation of his debarment terms prompted our ASG to investigate the entities with which he was affiliated. The investigation revealed that the debarred physician was practicing at two medical facilities.

In December 2024, our office issued pre-debarment notifications to the two medical facilities informing them that the physician who is affiliated with them is debarred by OPM. The medical facilities were also informed that the debarred physician is not permitted to file or cause claims to be filed with FEHBP health insurance carriers for reimbursement of items or services furnished at non-debarred facilities, such as the two medical facilities. The pre-debarment notifications required a response from the facilities containing information as to how they will ensure the debarred physician's services will no longer be billed to the FEHBP. We also asked the medical facilities to confirm that the physician does not directly or indirectly have an ownership stake or controlling interest in the facilities.

In February 2025, one medical facility confirmed that the debarred physician does not have direct or indirect ownership or control in it. The medical facility has taken measures to prevent the debarred physician's services from being billed to the FEHBP health insurance carriers and issued the debarred physician a 90-day notice of termination. The second facility has not responded to our pre-debarment letter. However, if either facility files additional claims through its medical facility for services rendered by the debarred physician, OPM may pursue debarment of the facility, in compliance with 5 U.S.C. §§ 8902a(c) and (d).

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries

Indictments and Criminal Informations	2
Arrests	4
Convictions	2
Criminal Complaints/Pre-Trial Diversion	0
Subjects Presented for Prosecution	24
Federal Venue	22
Criminal	16
Civil	8
State Venue	0
Local Venue	2
Dollars Submitted as Potential Fraud, Waste, or Abuse by FEHBP Carriers[5]	$208,875,338
Dollars Presented by OPM OIG to the U.S. Department of Justice[6]	$72,292,782
Expected Recovery Amount to OPM Programs	$2,747,818
Civil Judgments and Settlements	$2,396,401
Criminal Fines, Penalties, Assessments, and Forfeitures	$263,832
Administrative Recoveries	$87,585
Expected Recovery Amount for All Programs and Victims[7]	$347,000,783

[5] Dollars Submitted as Potential Fraud, Waste, or Abuse by FEHBP Carriers is the amount of money that FEHBP health insurance carriers submitted to the OPM OIG as potential fraud, waste, or abuse. These referrals often represent potential fraud, waste, or abuse that require further analysis of medical claims data or investigation. FEHBP health insurance carriers may attempt to recover fraudulent health care spending via administrative methods (such as through the claims offset process) when the OPM OIG chooses not to investigate an allegation.

[6] Dollars Presented by OPM OIG to the U.S. Department of Justice is the potential financial loss due to fraud, waste, and abuse that OPM OIG criminal investigators presented to the U.S. Department Justice. This represents the financial exposure of cases the OPM OIG expends investigative resources on, regardless of whether the case is ultimately accepted for prosecution.

[7] Expected Recovery Amount for All Programs and Victims is the amount of criminal fines/penalties and civil judgments/settlements returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures, 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 credit for the fines, penalties, assessments, and forfeitures.

Corrigendum: In the OPM OIG Semiannual Report for April 1, 2024, to September 30, 2024, the OPM OIG did not report a $4,444,417 recovery to the FEHBP associated with an OPM OIG criminal investigation. This was not reported because of a database error within OPM OIG's investigative tracking system that has since been resolved. The actual expected recovery amount to OPM programs for the period from April 1, 2024, to September 30, 2024, was $6,336,474.

Investigative Administrative Actions

FY 2025 Investigative Reports Issued	119
Issued between October 1, 2024, and March 31, 2025	119
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	1
Personnel Suspensions, Terminations, or Resignations	0
Referrals to the OPM OIG Office of Audits	0
Referrals to an OPM Program Office	3

Administrative Sanctions Activities

FEHBP Debarments and Suspensions Issued	520
FEHBP Provider Debarment and Suspension Inquiries	1,863
FEHBP Debarments and Suspensions in Effect at the End of the Reporting Period	39,982

Table 1: Enforcement Activities

	OPM Healthcare & Insurance Office	OPM Retirement Services Office	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened					
Investigations[8]	32	12	4	1	49
Preliminary Investigations[9]	31	3	2	0	36
FEHBP Carrier Notifications/ Program Office	700	14	0	0	714
Complaints – All Other Sources/Proactive[10]	168	8	0	8	184
Cases Closed					
Investigations	32	7	0	3	42
Preliminary Investigations	39	3	0	4	46
FEHBP Carrier Notifications/ Program Office	608	10	0	0	618
Complaints – All Other Sources/Proactive	148	6	0	1	155
Cases In Progress[11]					
Investigations	118	17	0	6	141
Preliminary Investigations	21	3	0	4	28
FEHBP Carrier Notifications/ Program Office	184	6	0	0	190
Complaints – All Other Sources/Proactive	29	2	0	6	37

[8] This includes preliminary investigations from this reporting period and previous reporting periods converted to investigations during this reporting period.
[9] This includes complaints or carrier notifications from this reporting period and previous reporting periods converted to preliminary investigations during this reporting period.
[10] This excludes allegations received via the OPM OIG Hotline, which are reported separately in this report.
[11] Cases in progress may have been opened in a previous reporting period.

OIG Hotline Complaint Activity

OIG Hotline Complaints Received	**2,774**
Sources of OIG Hotline Cases Received	
Website	1,894
Telephone	682
Letter	97
Email	101
In-Person	0
OPM Program Office	
Healthcare and Insurance	547
Customer Service	88
Health Care Fraud, Waste, and Abuse Complaint	257
Other Health Care and Insurance Issues	202
Retirement Services	842
Customer Service	416
Retirement Fraud, Waste, and Abuse Complaint	90
Other Retirement Services Issue	336
Other OPM Program Offices/Internal Matter	530
Customer Service	9
Other OPM Program Fraud, Waste, and Abuse Complaint	36
Other OPM Program Issue[12]	485
External Agency Issue (Unrelated to OPM)	855
OIG Hotline Cases Reviewed and Closed/Converted[13]	**2,236**
Outcome of OIG Hotline Complaints Closed	
Referred to External Agency	6
Referred to OPM Program Office	371
Retirement Services	116
Healthcare and Insurance	175
Other OPM Programs/Internal Matter	80
No Further Action	1,852
Converted to Case	7

[12] During this reporting period, the OPM OIG received many hotline contacts about Administration initiatives such as the Deferred Resignation Program. The OPM OIG evaluated these hotline contacts based on their relevancy to OPM programs and operations.

[13] Includes hotline cases that may have been received in a previous reporting period.

OIG Hotline Complaints Pending[14]	**611**
By OPM Program Office	
Healthcare and Insurance	142
Retirement Services	276
Other OPM Program Offices/Internal Matters	190
External Agency Issue (unrelated to OPM)	3

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

Legal and Legislative Activities

Under the Inspector General Act of 1978, as amended (5 U.S.C. §§ 401–424), OIGs are required to obtain legal advice from a counsel reporting directly to an inspector general (IG). This reporting relationship ensures that the OIG receives independent and objective legal advice. The OPM OIG Office of Legal and Legislative Affairs (OLLA) discharges this statutory responsibility in several ways, including by providing advice to the IG and OIG office components on a variety of legal issues, tracking and commenting on legislative matters affecting the work of the OIG, and advancing legislative proposals that address waste, fraud, and abuse against and within OPM programs.

During this reporting period, our office advised the IG and other OIG components on many legal and regulatory matters. OLLA also evaluated proposed and draft legislation related to OPM and the OIG's programs and operations and provided comments on legislation to Congress.

Congressional Engagements

OLLA coordinated 21 engagements with congressional stakeholders since our last semiannual report. In coordination with other OIG components, we worked to field inquiries, provide information, and facilitate briefings to address specific congressional requests and inquiries covering a range of topics, including the OPM's Top Management Challenges for FY 2025 report, OIG's top monetary recommendations, Retirement Services, and whistleblower protections.

Moreover, we provided technical assistance on legislation related to FEHBP enrollment and eligibility, which addresses a longstanding OIG recommendation to increase FEHBP integrity by establishing a centralized enrollment portal. A centralized portal would allow FEHBP enrollees to submit eligibility documentation to one system maintained by OPM. Currently, this information is maintained at employing offices across the federal government.

We have also received increased congressional interest in emerging risks at OPM and the potential impact on operations both at the agency and the OIG.

Legislation to Enhance Health Benefits Program Integrity

The OIG had the opportunity to review and provide technical assistance on the FEHB Protection Act of 2025 (H.R. 2193 — 119th Congress: FEHB Protection Act of 2025). Similar to a version of the bill from the 118th Congress, this legislation would require OPM to implement a process to verify the eligibility of family members who are enrolled in the FEHBP, conduct an audit of these members, and develop a process to disenroll those who are found to be ineligible. Notably, the version of the FEHB Protection Act from the 119th Congress also includes a legislative proposal that OPM and the OIG jointly shared with congressional

stakeholders over the last two reporting periods. The addition of this proposal allows funding from the existing Employee Health Benefits fund to be made available for OPM to improve and centralize FEHBP enrollment systems and for the OIG to conduct program oversight.

The OIG has previously estimated that the FEHBP is potentially losing up to $3 billion annually as a result of ineligible members because OPM did not have a family member verification process in place.[15] The OIG has highlighted for several years in our annual report on OPM's top management challenges and during multiple engagements with congressional staff that centralized enrollment is critical to addressing the issue of ineligible members in the FEHBP. With the FEHB Protection Act, OPM would have the opportunity to implement this OIG recommendation, and the OIG could enhance program oversight efforts with the shared goal of safeguarding the integrity of the FEHBP.

After reviewing the FEHB Protection Act, the OIG provided technical assistance to the House Committee on Oversight and Government Reform staff that would further support the overall goals of the legislation by strengthening OIG oversight with provisions for records retention and investigative referrals. We look forward to continuing to work with congressional stakeholders to address eligibility issues and improper payments in the FEHBP.

Risk Assessments at OPM

The OIG has a longstanding practice of conducting risk assessments at OPM not only as part of the future work planning process but also to determine if there are any emerging risks that require immediate OIG oversight. As part of our regular, established process, we routinely monitor and assess risks at the agency and can exercise flexibility in our annual oversight plan to direct resources to the areas of highest risk as we identify them in real time.

We also take our statutory mandate to report both to the OPM Director and to Congress seriously. To the extent that we are able, we adapt our plans to address questions and requests from the agency and Congress. For example, in response to a congressional request from the House Committee on Oversight and Government Reform minority members, we identified ways in which members' concerns could be addressed through regularly scheduled oversight work or in a new engagement that would align with our assessment of agency risks.

As we continue to receive requests for information and specific reviews from interested stakeholders, we will evaluate how and if we are best suited to respond in keeping with our mission to provide independent and objective oversight of OPM's services and programs to improve efficiency and effectiveness.

[15] Final Audit Report, Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs (4A-HI-00-19-007), October 30, 2020.

Appendix I-A: Final Reports Issued With Questioned Costs for OPM Insurance Programs

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	13	$303,688,559
B. Reports issued during the reporting period with questioned costs	3[1]	$29,127,430[2]
Subtotals (A+B)	16	$332,815,989
C. Reports for which a management decision was made during the reporting period:	1	$40,784,439
1. Net disallowed costs	N/A	$36,523,640
Disallowed costs during the reporting period	N/A	$36,678,945[3]
Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$155,305[4]
2. Net allowed costs	N/A	$4,260,799
Allowed costs during the reporting period	N/A	$4,105,494[5]
Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$155,305[4]
D. Reports for which no management decision has been made by the end of the reporting period	15	$292,031,550
E. Reports for which no management decision has been made within 6 months of issuance	12	$274,512,993

[1] Does not include one report that was previously issued with questioned costs.
[2] Includes $1,771,904 in additional net questioned costs from one previously issued report with questioned costs.
[3] Represents the management decision to support questioned costs and establish a receivable during the reporting period.
[4] Represents questioned costs which were determined by management to be allowable charges per the contract, subsequent to an initial management decision to disallow and establish a receivable.
[5] Represents questioned costs (overpayments) which management allowed and for which no receivable was established. It also includes the allowance of underpayments to be returned to the carrier.

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

Subject	Number of Reports	Questioned Costs
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 questioned costs	0	$0
Subtotals (A+B)	0	$0
C. Reports for which a management decision was made during the reporting period:	0	$0
1. Net disallowed costs	N/A	$0
2. Net allowed costs	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 OPM Insurance Programs

Subject	Questioned Costs
A. Value of open recommendations at the beginning of the reporting period	$303,688,559
B. Value of new audit recommendations issued during the reporting period	$29,127,430[1]
Subtotals (A+B)	$332,815,989
C. Amounts recovered during the reporting period	$36,523,640
D. Amounts allowed during the reporting period	$4,260,799
E. Other adjustments	$0
Subtotals (C+D+E)	$40,784,439
F. Value of open recommendations at the end of the reporting period	$292,031,550

[1] Includes $1,771,904 in additional net questioned costs from one report that was previously issued with questioned costs.

Appendix III: Final Reports Issued With Recommendations for Better Use of Funds

Subject	Number of Reports	Questioned Costs
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 questioned better use of funds amounts	0	$0
Subtotals (A+B)	0	$0
C. Reports for which a management decision was made during the reporting period:	0	$0
D. Reports for which no management decision has been made by the end of the reporting period	0	$0
E. Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix IV: Audit Reports Issued

Report Number	Subject	Date Issued	Questioned Costs
2023-IAG-025	The U.S. Office of Personnel Management's Budget Officer Group in Washington, DC	October 7, 2024	—
PSHB-089	U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Customer Support Experience in Washington, DC	October 23, 2024	—
2024-ISAG-008	Federal Information Security Modernization Act Audit - Fiscal Year 2024 in Washington, DC	October 30, 2024	—
2023-SAG-019	Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017 through 2022 in St. Louis, Missouri	November 14, 2024	$18,443,118
2024-IAG-017	The U.S. Office of Personnel Management's Fiscal Year 2024 Consolidated Financial Statements in Washington, DC	November 15, 2024	—
2023-IAG-021	The U.S. Office of Personnel Management's Audit Resolution Process Group in Washington, DC	November 26, 2024	—
PSHB-086	U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Interim Report in Washington, DC	December 10, 2024	—
2024-ISAG-007	Information Systems General and Application Controls at QualChoice in Little Rock, Arkansas	December 11, 2024	—
2024-ERAG-002	Florida Blue in Jacksonville, Florida	January 8, 2025	$8,466,906
2023-CRAG-023	Health Net of California, Inc. – Northern and Southern Regions in Cypress, California	January 13, 2025	—
2024-CAAG-011	Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of South Carolina for Contract Years 2020 through 2022 in Columbia, South Carolina	March 25, 2025	—
2024-ERAG-004	HMO Missouri, Inc. in Mason, Ohio	March 25, 2025	$445,502
		TOTAL	$27,355,526

Appendix V: Priority Open Recommendations

The OPM OIG identifies its three highest priority open recommendations on Oversight.gov. These priority recommendations are those the OIG believes, when implemented, will have the most benefit to OPM's operations, programs, or funds.

Priority open recommendations warrant priority attention from OPM leadership because their implementation could significantly improve program management and payment integrity. All three of our current priority recommendations focus on strengthening the FEHBP to reduce costs and provide better services to federal employees and their families.

Report Number	Subject	Date Issued	Rec #	Recommendation
1C-59-00-20-043	Audit of the Federal Employees Health Benefits Program Operations at Kaiser Foundation Health Plan, Inc.	August 16, 2022	1	We recommend that OPM revise or replace the FEHBP MLR requirements to provide a reliable measure of the premium dollars spent on the FEHBP program, including the impact of carrier corporate structure and the current community-rated product market.
4A-HI-00-18-026	FEHB Program Integrity Risks Due to Contractual Vulnerabilities	April 1, 2021	7	We recommend that OPM modify Section 2.3(g) and 2.3(g)(ii) to provide expectations for how carriers are to proactively identify overpayments and to define what it means by egregious errors.
1H-01-00-18-039	Federal Employees Health Benefits Program Prescription Drug Benefit Costs	March 31, 2020	1	We recommend that OPM conduct a new, comprehensive study by seeking independent expert consultation on ways to lower prescription drug costs in the FEHBP, including but not limited to the possible cost saving options discussed in this report.

The OPM OIG maintains a listing of all open recommendations on the Open Recommendations Dashboard.

Appendix VI: Summary of Reports More Than 6 Months Old Pending Corrective Action

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-08-025	The U.S. Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements in Washington, DC	November 14, 2008	1	0	6
4A-CF-00-09-037	The U.S. Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statements in Washington, DC	November 13, 2009	1	0	5
4A-CF-00-10-015	The U.S. Office of Personnel Management's Fiscal Year 2010 Consolidated Financial Statements in Washington, DC	November 10, 2010	2	0	7
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, DC	November 14, 2011	1	0	7
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, DC	November 15, 2012	1	0	3
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, DC	December 13, 2013	1	0	1
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, DC	November 10, 2014	2	0	4

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, DC	November 13, 2015	2	0	5
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, DC	November 14, 2016	7	0	19
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, DC	November 13, 2017	9	0	18
L-2018-1	Management Advisory Report - Review of the U.S. Office of Personnel Management's Non-Public Decision to Prospectively and Retroactively Re-Apportion Annuity Supplements in Washington, DC	February 5, 2018	3	0	3
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, DC	May 10, 2018	1	0	2
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, DC	November 15, 2018	9	0	23
4A-CI-00-18-037	The U.S. Office of Personnel Management's Compliance with the Federal Information Technology Acquisition Reform Act in Washington, DC	April 25, 2019	1	0	5
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, DC	June 3, 2019	1	0	4

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, DC	October 23, 2019	3	0	23
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, DC	November 18, 2019	9	0	20
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, DC	February 27, 2020 Reissued March 31, 2020	0	2	2
4A-RS-00-18-035	The U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, DC	April 2, 2020	3	4	12
4A-CF-00-20-014	The U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, DC	May 14, 2020	1	0	3
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	3	0	8
4A-HI-00-19-007	The U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, DC	October 30, 2020	5	1	24
4A-RS-00-19-038	The U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, DC	October 30, 2020	0	5	8

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
4A-CF-00-20-024	The U.S. Office of Personnel Management's Fiscal Year 2020 Consolidated Financial Statements in Washington, DC	November 13, 2020	9	0	21
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021	0	1	2
4A-HI-00-18-026	Management Advisory Report - FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, DC	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, DC	May 17, 2021	1	0	4
1C-8W-00-20-017	UPMC Health Plan, Inc. in Pittsburgh, Pennsylvania	June 28, 2021	4	0	17
1H-99-00-20-016	Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts in Washington, DC	July 29, 2021	3	0	3
4A-CF-00-21-027	The U.S. Office of Personnel Management's Fiscal Year 2021 Consolidated Financial Statements in Washington, DC	November 12, 2021	9	0	20
1A-10-17-21-018	Claims Processing and Payment Operations at Health Care Service Corporation for Contract Years 2018 through 2020 in Chicago, Illinois	February 23, 2022 Reissued March 16, 2022	0	4	18
2022-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, DC	June 23, 2022	1	0	6
1C-59-00-20-043	Kaiser Foundation Health Plan, Inc. in Oakland, California	August 16, 2022	1	0	16

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
1A-10-15-21-023	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	August 25, 2022	1	0	11
2022-IAG-003	The U.S. Office of Personnel Management's Fiscal Year 2022 Consolidated Financial Statements in Washington, DC	November 14, 2022	8	0	15
2022-CRAG-004	MercyCare Health Plans in Janesville, Wisconsin	February 2, 2023	2	0	4
2022-CRAG-0010	The Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc. in Las Vegas, Nevada	February 15, 2023	3	2	20
1H-08-00-21-015	Group Health Incorporated's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2015 through 2019 in St. Louis, Missouri	February 16, 2023	10	0	12
2022-CAAG-0023	Claims Processing and Payment Operations at Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020 in Durham, North Carolina	March 3, 2023	2	0	5
2022-CAAG-0014	Evaluation of COVID-19's Impact on FEHBP Telehealth Services and Utilization in Washington, DC	March 6, 2023	5	0	5
2023-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, DC	May 22, 2023	1	0	2
2022-IAG-0019	The U.S. Office of Personnel Management's Retirement Services' Settlement Process in Washington, DC	June 15, 2023	0	3	5

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2022-CAAG-035	Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021 in Washington, DC	June 27, 2023	9	0	11
2022-ISAG-036	Information Systems General and Application Controls at Health Alliance Medical Plans, Inc. in Champaign, Illinois	July 13, 2023	0	6	17
2022-CRAG-037	UnitedHealthcare Insurance Company, Inc. in Minnetonka, Minnesota	October 30, 2023	3	0	17
2023-CAAG-001	Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021 in Washington, DC	November 7, 2023	1	2	7
2023-IAG-017	The U.S. Office of Personnel Management's Fiscal Year 2023 Consolidated Financial Statements in Washington, DC	November 13, 2023	9	0	15
2023-OEI-001	Evaluation of the U.S. Office of Personnel Management's Processing of Initial Retirement Claim Applications in Washington, DC	November 15, 2023	3	0	5
2022-CAAG-001	The Office of Personnel Management's Disputed Claims Process for years 2018 through 2020 in Washington, DC	December 20, 2023	15	0	15

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2023-CAAG-009	Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021 in Washington, DC	February 15, 2024	1	1	3
2023-CAAG-020	FEHBP Claims Processing and Payment Operations as Administered by Regence for Contract Years 2019 through 2021 in Tacoma, Washington	February 20, 2024	1	2	3
2023-ERAG-005	Blue Cross Blue Shield of North Carolina in Durham, North Carolina	February 26, 2024	0	1	8
2023-CAAG-022	Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of Florida for Contract Years 2020 through 2022 in Jacksonville, Florida	March 6, 2024	1	1	2
2022-SAG-029	American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021 in Glenn Burnie, Maryland	March 29, 2024	8	4	17
2024-IAG-010	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, DC	May 29, 2024	1	1	5
2024-CRAG-006	Final Audit Research Results: OPM's Subscription Income Process in Washington, DC	June 17, 2024	3	0	3
2023-ISAG-024	Information Systems General and Application Controls at Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin	July 15, 2024	0	3	16

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total Issued
2024-ISAG-009	Information Technology Security Controls of the U.S. Office of Personnel Management's White House Fellows System in Washington, DC	August 8, 2024	1	0	1
2023-OEI-002	Evaluation of the U.S. Office of Personnel Management's Property Management Process in Washington, DC	August 28, 2024	0	3	3
PSHB-088	The U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Collection of Members' Eligibility Documentation in Washington, DC	September 13, 2024	3	0	3
		TOTAL	196	46	560

[1] As defined in OMB Circular No. A-50, resolved means that the audit organization and agency management agree on action to be taken on reported findings and recommendations; however, corrective action has not yet been implemented. Outstanding and unimplemented (open) recommendations listed in this appendix that have not yet been resolved are not in compliance with the OMB Circular No. A-50 requirement that recommendations be resolved within 6 months after the issuance of a final report.

Appendix VII: Most Recent Peer Review Results

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

Subject	Date of Report	Result
System Review Report on the U.S. Department of State Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	January 30, 2025	Pass[1]
System Review Report on the U.S. Office of Personnel Management Office of the Inspector General Audit Organization (*Issued by the Office of Inspector General, U.S. Department of Labor*)	September 4, 2024	Pass
External Quality Assessment Review of the Office of the Inspector General for the U.S. Office of Personnel Management Investigative Operations (*Issued by the Tennessee Valley Authority Office of the Inspector General*)	January 19, 2023	Compliant[2]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Railroad Retirement Board (*Issued by the Office of the Inspector General, U.S. Office of Personnel Management*)	March 28, 2024	Compliant
External Peer Review Report on the Office of Evaluations of the Office of the Inspector General for the U.S. Office of Personnel Management (*Issued by the U.S. General Services Administration Office of Inspector General*)	June 30, 2022	Compliant[3]
External Peer Review Report on the Office of the Inspector General for the Library of Congress (*Issued by the Office of the Inspector General, U.S. Office of Personnel Management*)	July 22, 2021	Compliant

[1] A peer review rating of pass is issued when the reviewing OIG concludes that the system of quality control for the reviewed OIG has been suitably designed and complied with to provide the audit organization 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 OIG 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 IG Act are properly exercised.
[3] A rating of compliant conveys that the reviewed OIG has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards for inspections and evaluations are followed.

Appendix VIII: Investigative Recoveries

Investigative Recovery Area	Sum of Total Recovery Amount	Sum of OPM Recovery Net
Administrative Action	$87,585	$87,585
Retirement Services	$87,585	$87,585
CSRS & FERS	$87,585	$87,585
Administrative Debt Recovery	$87,585	$87,585
Civil Action	$346,436,446	$2,396,401
Healthcare and Insurance	$346,283,216	$2,324,948
FEHBP	$346,283,216	$2,324,948
Retirement Services	$153,230	$71,453
CSRS & FERS	$153,230	$71,453
Criminal Action	$476,752	$263,832
Healthcare and Insurance	$348,719	$135,799
FEHBP	$348,719	$135,799
Retirement Services	$128,033	$128,033
CSRS & FERS	$128,033	$128,033
TOTAL	$347,000,783	$2,747,818

Reporting Requirements in the Inspector General Act of 1978, As Amended

Requirement	Location
Review of legislation and regulations	Legal and Legislative Activities
Significant problems, abuses, and deficiencies as well as the associated reports and recommendations for corrective action	Audit Activities, Evaluation Activities
Recommendations made before the reporting period, for which corrective action has not been completed	OIG website
Significant investigations closed during the reporting period	Statistical Summary of Enforcement Activities
Number of convictions closed during the reporting period resulting from investigations	Statistical Summary of Enforcement Activities
Audit, inspection and evaluation reports issued during the reporting period, including information regarding the value of questioned costs and recommendations for funds put to better use	Appendices I–IV
Management decisions made during the reporting period with respect to audits, inspections, and evaluations issued during a previous reporting period	Summary of Reports More Than 6 Months Old Pending Corrective Action
Reportable information under section 804(b) of the Federal Financial Management Improvement Act of 1996	Information Systems Audits, Internal Audits
Information pertaining to peer review by other OIGs	Most Recent Peer Review Results
Statistical tables showing the number of investigative reports issued, persons referred for criminal prosecution, and indictments and criminal informations during the reporting period	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity, Investigative Recoveries
Metrics used for developing the data for the table showing investigative reports, persons referred for criminal prosecution, and indictments and criminal informations	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity
Reports on investigations involving substantiated misconduct by senior government employees or officials	No activity
Descriptions of whistleblower retaliation, including implicated individuals and any consequences imposed	No activity
Agency attempts to interfere with OIG independence	No activity
Closed investigations, audits, and evaluations not disclosed to the public	Statistical Summary of Enforcement Activities, OIG Hotline Complaint Activity
Closed investigations involving senior government employees, not disclosed to the public	No activity

See James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, H.R. 7776, 117th Cong. § 5273 (2022).

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