SEMIANNUAL REPORT TO CONGRESS

APRIL 1, 2020–SEPTEMBER 30, 2020

U.S. OFFICE OF PERSONNEL MANAGEMENT

Office of the Inspector General

PRODUCTIVITY INDICATORS

FINANCIAL IMPACT

Audit Recommendations for Recovery of Funds
$12,373,064

Management Commitments to Recover Funds
$14,103,553

Recoveries Through Investigative Actions **$12,532,192**

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

ACCOMPLISHMENTS

17
Audit Reports Issued

Evaluation Reports Issued 2

Management Advisories Issued 1

465
Investigations and Complaints Closed

Indictments and Criminal Informations
24

220
Arrests

11
Convictions

1,084
Hotline Contacts and Complaints Received

Hotline Contacts and Complaints Closed
1,520

442
Debarments and Suspensions of Providers from the Federal Employees Health Benefits Program

2,327
Debarment and Suspension Inquiries Regarding Federal Employees Health Benefits Program's Providers

MESSAGE FROM THE DEPUTY INSPECTOR GENERAL PERFORMING THE DUTIES OF THE INSPECTOR GENERAL

The Coronavirus Aid, Relief, and Economic Security (CARES) Act contained a number of provisions related to health care delivery, including funding to modernize health care infrastructure, expand access to telehealth, increase public health activities, and deliver grants or loans to providers to offset losses attributable to the novel coronavirus (COVID-19). While the U.S. Office of Personnel Management (OPM) administers the Federal Employees Health Benefits Program (FEHBP), which covers more than eight million full-time permanent civilian employees, retirees, and eligible family members of the U.S. Government, the agency did not receive CARES Act funding specifically related to health care or the FEHBP. Nonetheless, our office has been actively engaged in tracking COVID-19 trends and risk areas that impact the OPM-administered Federal health care-related programs.[1] Since the onset of the pandemic, we have been following three areas closely: the emerging risks associated with COVID-19 testing, the trends related to the avoidance or delay of medical care, and the impact of COVID-19 on the ongoing opioid epidemic.

The CARES Act also established the Pandemic Response Accountability Committee (PRAC) within the Council of the Inspectors General on Integrity and Efficiency (CIGIE) to promote transparency and oversight of both Federal CARES Act funding and the Federal Government's COVID-19 response. The Healthcare Subgroup of the PRAC is comprised of Offices of Inspectors General (OIGs) that oversee agencies providing or affected by the provision of Federal health care-related programs. As a member of the PRAC Healthcare Subgroup our office coordinates and shares insights with other OIGs, specifically regarding COVID-19 trends. The current focus of the Subgroup is analyzing COVID-19 testing across Federal health care-related programs.

In the FEHBP, we found that COVID-19 testing is widespread, occurring in all 50 states and territories. There were at least 473,000 individuals enrolled in the FEHBP who received a COVID-19 test through August 2020, with total costs of greater than $48 million.[2] While we have not yet directly observed specific instances of fraud, waste, and abuse associated with COVID-19 testing and treatment in the FEHBP, we will continue to monitor this area and focus future efforts on this topic.

Our analysis also uncovered a particularly concerning trend: we discovered that many Federal employees, retirees or annuitants, and their covered or eligible family members, may be avoiding or delaying medical care because of COVID-19 concerns. The Centers for Disease Control and Prevention (CDC) estimated that as of

[1] OPM received $12,100,000 in CARES Act funding to remain available until September 20, 2021, to prevent, prepare for, and respond to the coronavirus, domestically or internationally, including implementing technologies for digital case management, short-term methods to allow electronic submissions of retirement application packages in support of paper-based business operations, and increased telecommunications.

[2] Based on analysis of claims data consisting of a subset of the FEHBP population, covering about 75 percent of enrolled individuals.

June 30, 2020, 41 percent of U.S. adults delayed or avoided medical care, including routine preventive care.[3] We saw clear evidence of this trend in our analysis of FEHBP claims data in 2020. We presented this information to OPM Healthcare & Insurance (H&I) officials in August 2020 to help them better understand the factors and consequences (for example, increased mortality and morbidity risks) associated with health care avoidance, and work with FEHBP health carriers to target outreach encouraging FEHBP members to seek timely routine care.

Finally, concurrent with the COVID-19 pandemic, the opioid and drug abuse epidemic also continues nationwide. The interaction and complication of both health emergencies will harm Americans, including Federal employees, annuitants, and their families. It is too soon to know all of the ramifications of the COVID-19 pandemic on the opioid and drug abuse epidemic, but studies and news reports consistently point to the pandemic worsening the epidemic.[4] More than 40 states have reported increases in drug overdose deaths.[5] The difficulties of social isolation, strained support networks, economic hardship, and massive disruptions to the operation of the health care system (including substance abuse disorder treatment, sober homes, and recovery facilities) are consequences of the pandemic that may worsen the epidemic.

We are working to determine how COVID-19 has affected current trends in opioid use and the strategies in place to reduce opioid misuse within the FEHBP. We are also engaged in work that seeks to obtain reasonable assurance that only allowable opioid claims are prescribed and dispensed. Finally, we continue to combat the opioid crisis through investigations that target waste, fraud, and abuse in all areas of the opioid and drug abuse epidemic, from individual FEHBP beneficiaries who engage in dangerous behaviors such as doctor shopping to investigations of pharmaceutical companies that step outside the law and risk patient health. Many of our cases involve recovery programs and sober homes or other areas of health care fraud caused by the ancillary effects of the opioid and drug abuse epidemic. As these two public health emergencies continue, the OPM OIG will, through our investigations, audits, and evaluations, take necessary action to protect Federal employees, annuitants, and their families and OPM programs from fraud, waste, and abuse.

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

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[3] Czeisler MÉ, Marynak K, Clarke KE, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1250–1257. DOI: http://dx.doi.org/10.15585/mmwr.mm6936a4.

[4] See generally Ahmad FB, Rossen LM, Sutton P. Provisional drug overdose death counts. National Center for Health Statistics. 2020, https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm; American Medical Association, Issue brief: Reports of increases in opioid- and other drug-related overdose and other concerns during COVID pandemic, Updated October 6, 2020, https://www.ama-assn.org/system/files/2020-10/issue-brief-increases-in-opioid-related-overdose.pdf.

[5] Hilary Swift and Abby Goodnough, 'The Drug Became His Friend': Pandemic Drives Hike in Opioid Deaths, N.Y. Times, (September 29, 2020), https://www.nytimes.com/2020/09/29/health/coronavirus-opioids-addiction.html.

THE IMPACT OF COVID-19 ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

As noted in the Deputy Inspector General's Message, our work with the PRAC Healthcare Subgroup is initially focused on COVID-19 testing. The objectives are to identify the types of tests administered (viral or antibody), how many individuals were tested, the total costs paid for the tests by the FEHBP, and the setting in which the tests were administered. A CIGIE data brief covering these objectives for the PRAC Healthcare Subgroup member OIGs is scheduled to be issued in November 2020. We also analyzed FEHBP claims data to better understand the prevalence of positive COVID-19 diagnoses and the associated costs of treating the disease. Preliminary results of our review of COVID-19 testing and treatments are shown below.

Several related topics we are exploring include the avoidance or delay of medical care because of COVID-19 and the use of telehealth in response to the pandemic. We are particularly concerned with the decrease in preventive health care observed in the data. A study conducted by the CDC in June 2020 indicated 41 percent of U.S. adults delayed or avoided medical care because of COVID-19. The CDC reported this could lead to an increased risk of mortality and morbidity associated with preventable health conditions. It could also lead to increased long-term health care costs.

Our analysis of FEHBP health care claims data for the Federal employee, annuitant, and eligible family member population shows trends generally consistent with the CDC study. We observed steep declines in preventive health care across a range of services in March and April 2020. While the claims for these services rebounded somewhat starting in May 2020, our most recent data available shows preventive services trending down beginning in July and continuing into August. It is too early to tell how a potential surge in COVID-19 cases heading into autumn and winter may affect future utilization, but the current direction is concerning. Finally, we observed an increase in telehealth utilization coinciding with the decline in preventive health care. While telehealth may be beneficial in some situations, it cannot replace routine diagnostic testing.

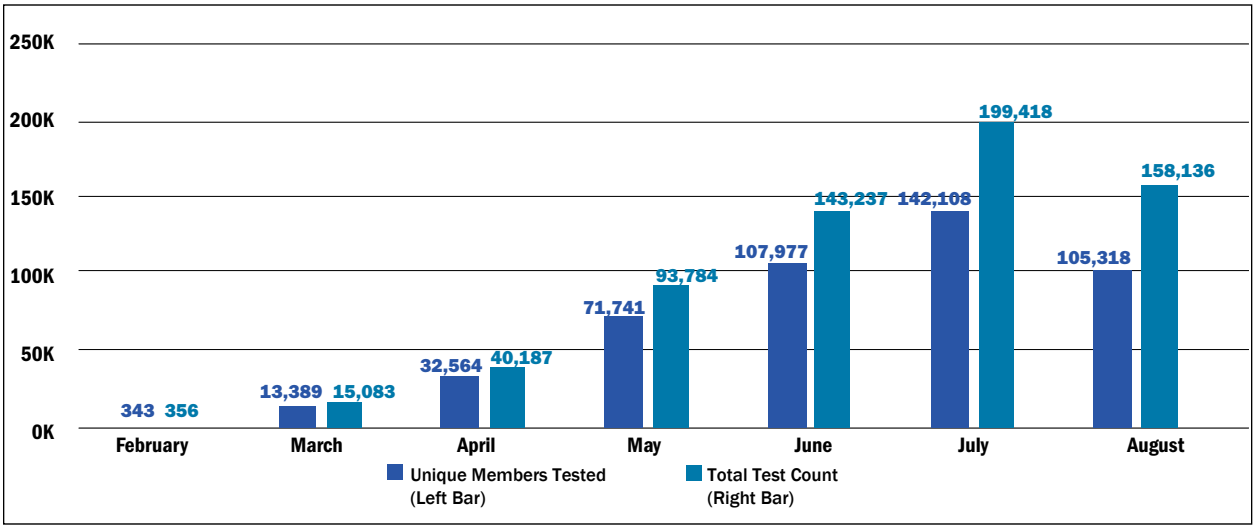
We presented this information in a meeting with OPM H&I officials in August 2020. The purpose of the briefing was to help FEHBP program officials better understand the factors and potential impact of delayed medical care, and to consider measures such as targeted health care delivery or messaging to encourage members to safely continue to manage their health care needs.

We analyzed claims data consisting of a subset of the FEHBP population, covering about 75 percent of enrolled individuals. Consequently, all of the below exhibits and discussion are based on this subset. We have no reason to believe the subset is not representative of the total FEHBP population, although we did not project the results of our work to that population.

Our analysis of COVID-19 test counts shows the number of tests rose each month since February, as expected, until August when the number of tests decreased. As evidenced by Exhibit 1 below, the greatest increase was observed between April and May.

Exhibit 1: Total Test Counts per Month

Please note figures include only a subset of FEHBP Health Plans



Our claims data has also shown the total cost to the program of COVID-19 testing increased during this time period, following the rise in the number of tests (see Exhibit 2 below). While the number of antibody tests was initially greater than the number of viral tests, the number of viral tests caught up to and exceeded the number of antibody tests beginning in March. This trend continued through the end of August. Finally, the average amount paid per test continues to rise. This is most likely due to the development and utilization of high-throughput, rapid viral tests not available at the beginning of the pandemic.

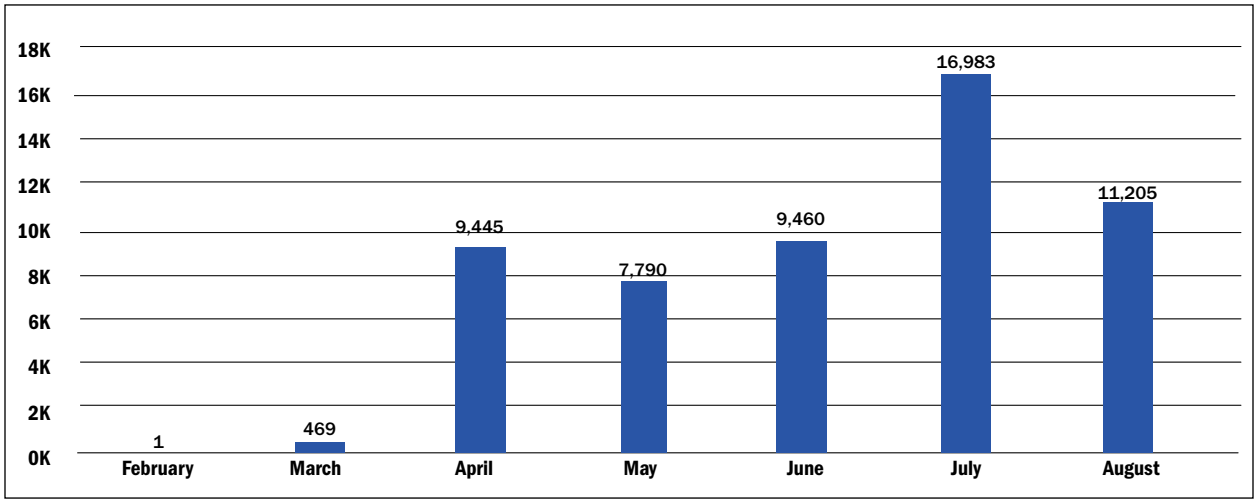
Exhibit 2: Number of Tests and Amount Paid for Tests per Month

Month	Viral Test Count	Antibody Test Count	Total Amount Paid	Average Amount Paid per Test
February	4	352	$4,278	$12.02
March	14,829	254	$828,005	$54.90
April	33,220	6,967	$2,766,538	$68.84
May	54,760	39,024	$6,127,515	$65.34
June	109,162	34,075	$10,766,719	$75.17
July	171,017	28,401	$15,692,276	$78.69
August	142,499	15,647	$12,480,650	$78.92
Total	**525,491**	**124,720**	**$48,665,981**	**$74.85**

Additionally, our data shows a total of 55,353 FEHBP participants have been diagnosed with COVID-19 as of August 31, 2020.[6] The number of COVID-19 diagnoses has risen over time in 2020, with the largest increases from the previous month observed in April and July (see Exhibit 3 below).

Exhibit 3: Total Diagnoses per Month

Please note figures include only a subset of FEHBP Health Plans



While the number of COVID-19 tests and diagnoses are both on the rise, the good news is the average amount paid per case to treat each patient significantly decreased from March to April, and again from April to May. This observation is consistent with reports outside of the FEHBP population. As health care professionals have learned more about the virus, treatment plans have narrowed, allowing providers to focus their efforts on only the most effective therapeutics.[7] In addition, the percentage of diagnoses resulting in hospitalization dropped drastically between March and May. During March, 94 percent of diagnoses resulted in hospitalizations, as compared to only 29 percent in April and 17 percent in May. Future analysis in this area will likely be necessary in order to understand both the changes in treatment over time, as well as the effect these changes have had on FEHBP health care costs.

[6] FEHBP participation is not limited to current Federal employees, but includes retirees and eligible family members as well.

[7] Chad Terhune, Drug costs for COVID-19 patients plunge at U.S. Hospitals, but may rise, Reuters (August 19, 2020), https://www.reuters.com/article/us-health-coronavirus-drug-costs/drug-costs-for-covid-19-patients-plunge-at-u-s-hospitals-but-may-rise-idUSKCN25F1BW.

Exhibit 4: Monthly COVID-19 Diagnosis, Payment, and Hospitalization Statistics

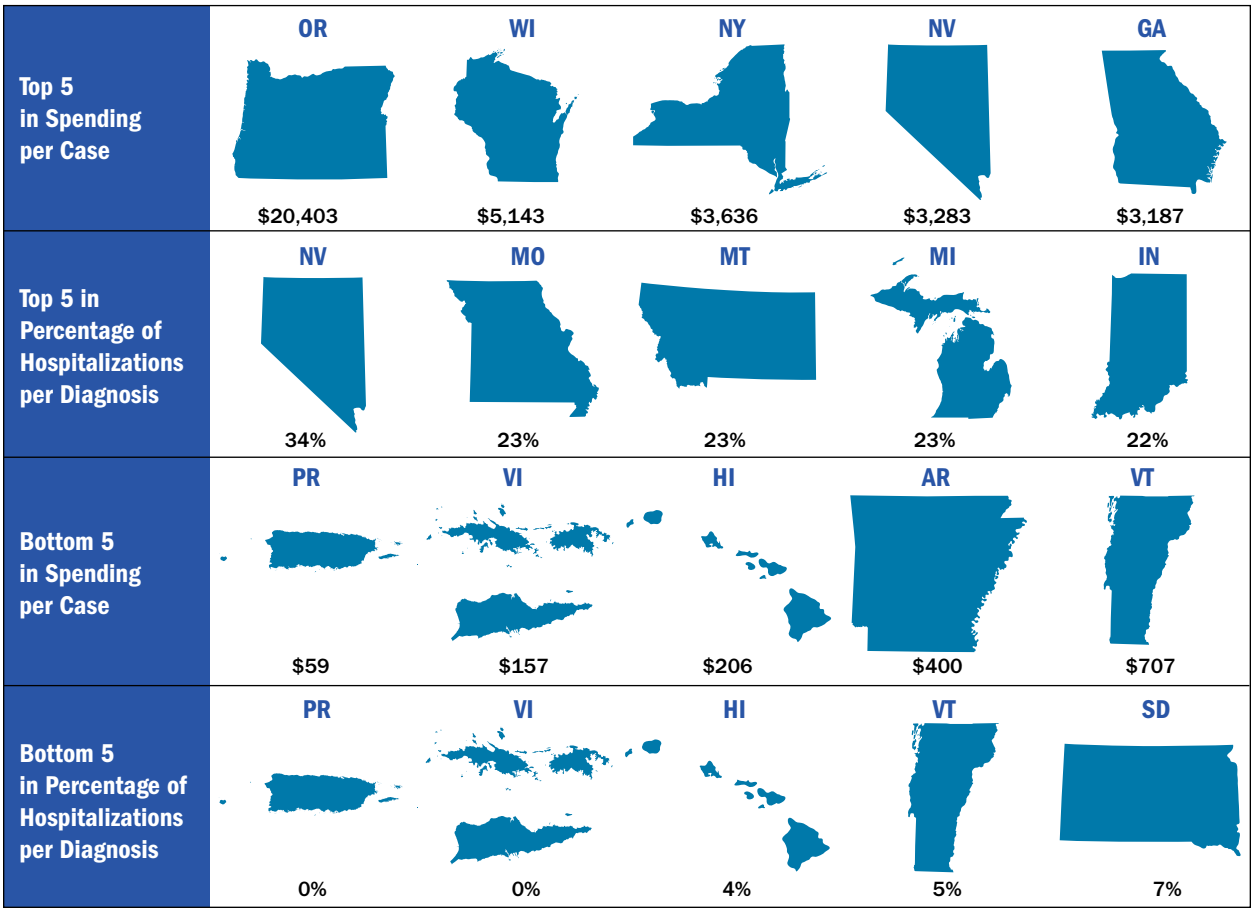
Please note exhibits include only a subset of FEHBP Health Plans

Month	Number of Cases	Total Amount Paid for Treatment	Average Amount Paid for Treatment	Percent of Diagnoses Resulting in Hospitalization
February	1	$0.00	$0.00	0%
March	469	$13,310,160	$28,380	94%
April	9,445	$30,992,357	$3,281	29%
May	7,790	$16,068,490	$2,063	17%
June	9,460	$16,533,601	$1,748	11%
July	16,983	$31,945,509	$1,881	14%
August	11,205	$14,999,761	$1,339	14%
Total	**55,353**	**$123,849,878**	**$2,237**	**17%**

The average total cost of treatment for a COVID-19 patient varied widely amongst different U.S. states/territories. The highest expenses were seen in Oregon and Wisconsin, while the lowest were observed in Puerto Rico and the U.S. Virgin Islands (see Exhibit 5 below). While the states that spent the lowest amount on treatment per case tend to coincide with those states that have seen the lowest percentage of hospitalizations, the same correlation is not seen on the higher end of the spectrum. Nevada is the only state out of the five that spent the most on care and was also in the top five states for the percentage of hospitalizations. The other four states that spent the most on care (Oregon, Wisconsin, New York, and Georgia) were not among the five states with the highest percentages of hospitalizations. We have not yet determined a likely cause for the increased spending in these states.

Exhibit 5: Top and Bottom Five States/Territories for COVID-19 Expenditures and Hospitalizations

Please note exhibits include only a subset of FEHBP Health Plans



Additionally, the states with the highest number of COVID-19 diagnoses have varied over the course of the pandemic. Our claims data has reflected the general trend in the United States that cases started out concentrated in the Northeast, then spread largely throughout the South. The top five states in diagnoses per 100,000 members from March through August were Louisiana, New Jersey, New York, Texas, and Mississippi, per Exhibit 6 below.

Exhibit 6: Top Five States in Diagnoses per 100,000 People

Please note exhibits include only a subset of FEHBP Health Plans

Month	Top 5 States in Diagnoses per 100,000 Members (in order)				
March	RI	NY	NJ	LA	IN
					
	29.56	27.05	25.42	24.65	15.86
April	NY	NJ	CT	MA	LA
					
	608.03	593.09	484.83	455.25	336.20
May	NY	NJ	MA	CT	IL
					
	383.18	364.32	285.65	257.38	256.53
June	TX	LA	AZ	TN	NJ
					
	319.37	285.77	273.03	243.03	222.90
July	LA	TX	TN	AL	MS
					
	626.45	606.07	435.40	417.36	404.47
August	LA	GA	AL	MS	TX
					
	391.11	326.83	316.52	271.82	243.81
Overall	LA	NJ	NY	TX	MS
					
	1798.66	1,631.96	1,441.79	1,304.81	1,177.53

Another impact of the COVID-19 pandemic is a reduction in preventive care. Use of preventive care benefits has been proven to avert unnecessary illnesses and diseases and has helped to mitigate health care costs. For example, the U.S. Department of Health and Human Services estimates that childhood immunizations save 33,000 lives and result in a total estimated cost savings of $43.3 billion each year.[8] However, after the onset of the COVID-19 pandemic, our claims data showed a drop in the utilization of these services. These reductions in preventive care services are in line with the reductions in preventive care outlined in a survey published by the CDC. The CDC's survey estimated that as of June 30, 2020, 41 percent of U.S. adults had delayed or avoided medical care, including emergency care and routine preventive care. Specifically, the survey found an estimated 32 percent drop in routine care.[9]

Our analysis of FEHBP claims data shows a decrease in preventive care services of about 35 percent when comparing January 2020 through June 2020 to the same time period in 2019. Exhibits 7 and 8 below illustrate the overall reductions in preventive care services between January 2019 and August 2020, as well as reductions in specific types of preventive care over the same period.

[8] Office of Disease Prevention and Promotion, Immunization and Infectious Disease, https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases.

[9] Czeisler MÉ, Marynak K, Clarke KE, et al. Delay or Avoidance of Medical Care Because of COVID-19–Related Concerns — United States, June 2020. MMWR Morb Mortal Wkly Rep 2020;69:1250–1257, https://www.cdc.gov/mmwr/volumes/69/wr/mm6936a4.htm.

Exhibit 7: Overall Preventive Care Trend January 2019–July 2020

Please note exhibits include only a subset of FEHBP Health Plans

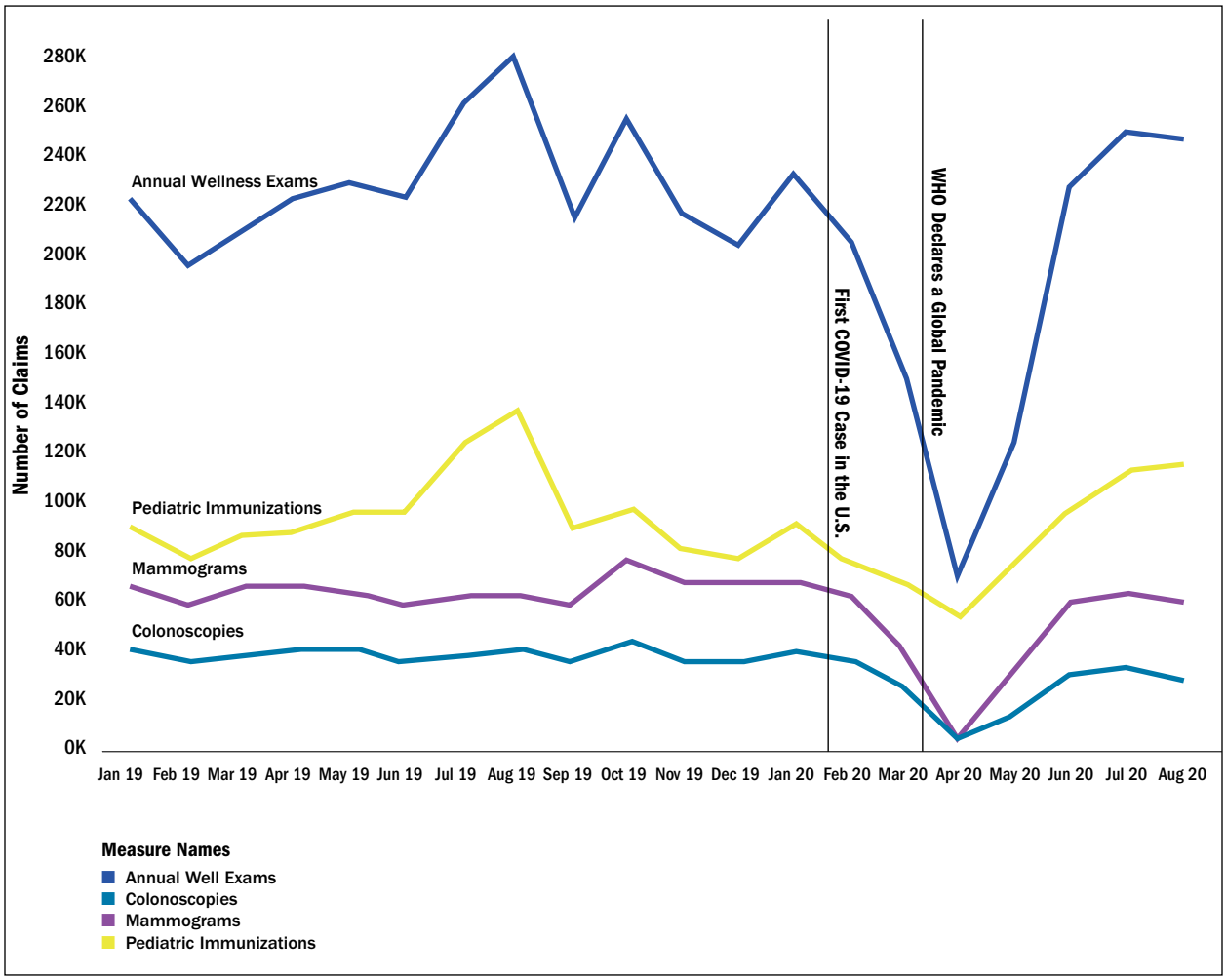
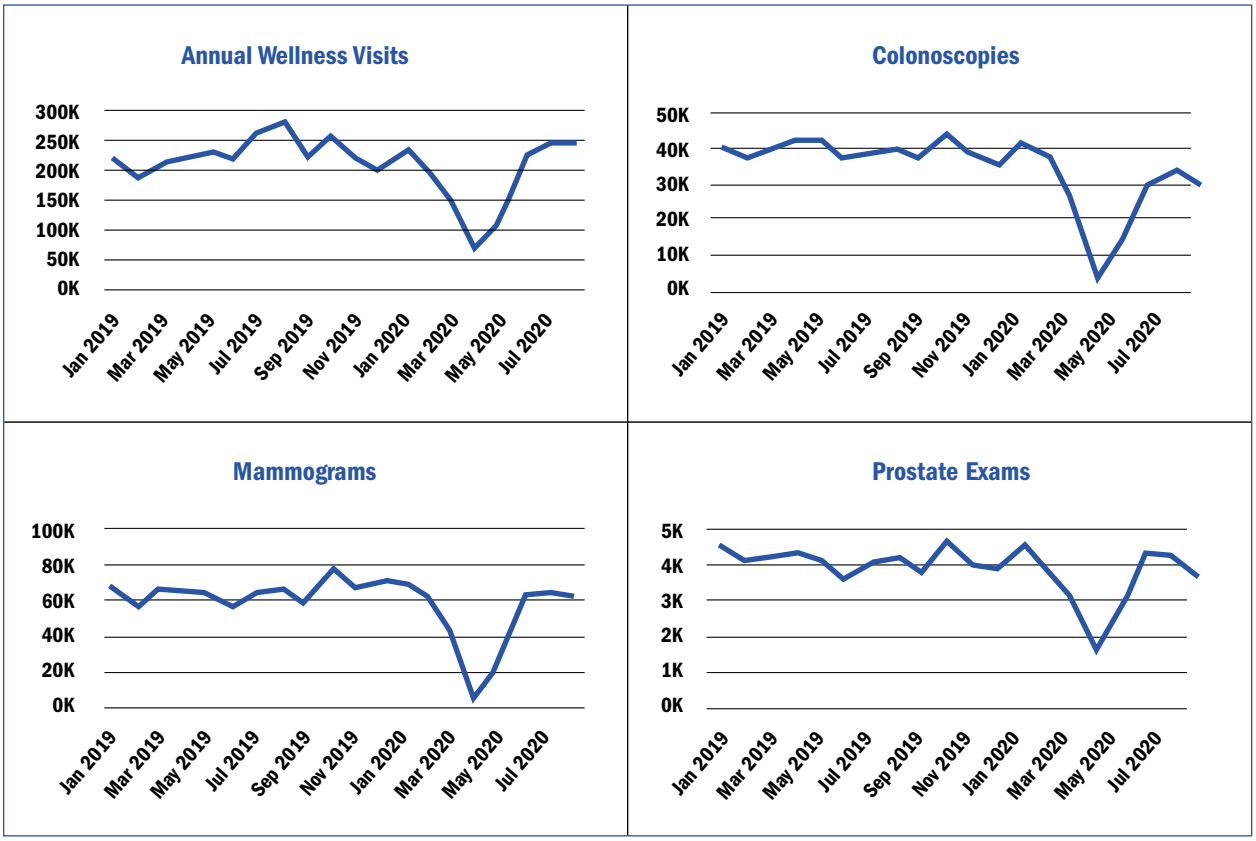


Exhibit 7: Overall Preventive Care Trend January 2019-July 2020. This line graph shows the number of medical insurance claims per month from January 2019 through August 2020 for four types of preventive care services: annual wellness exams, colonoscopies, mammograms, and pediatric immunizations. For each type of service, the graph demonstrates a basically stable number of claims per month from January 2019 through February 2020, with a pediatric immunizations spike in August 2019 and annual well exam spikes in August 2019, October 2019, and January 2020. Two vertical lines depict when the first case of COVID-19 appeared in the U.S. (beginning of February 2020) and when the World Health Organization declared a global pandemic (end of March 2020). Coinciding with these milestones, the chart shows a steep decline in claims for all types of preventive care services in March and April 2020. Claims for these services started to rebound in May through July; however, the trend back toward normal levels reversed in August 2020.

Exhibit 8: Preventive Care Trends by Procedure Type[10]

Please note exhibits include only a subset of FEHBP Health Plans



In addition to reductions in the preventive care services analyzed above, Exhibit 9 below illustrates reductions in pediatric immunizations. While most immunizations have continued to decline through August of this year, our data shows an uptick in some vaccinations during June. Overall, however, vaccinations for FEHBP members under the age of 22 dropped 16 percent from last year, despite enrollment in the analyzed subset of FEHBP Health Plans rising 1.54 percent between 2019 and 2020.

[10] The data in Exhibit 8 covers the period of January 2019 through August 2020.

Exhibit 9: Percent Change in Pediatric Vaccination Rates from 2019–2020, by Month (January–August)

Please note exhibits include only a subset of FEHBP Health Plans

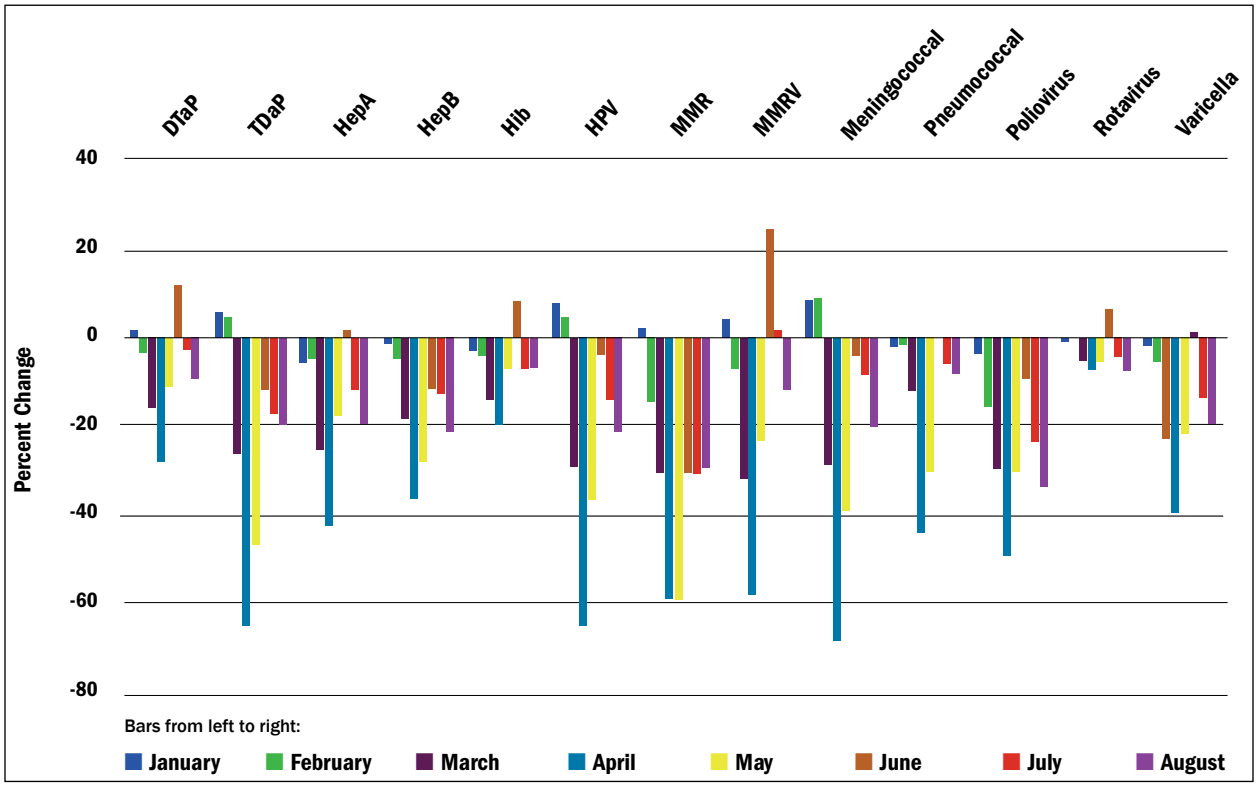


Exhibit 9: Percent Change in Pediatric Vaccination Rates from 2019–2020, by Month (January–August). Pediatric vaccinations include DTaP, TDaP, HepA, HepB, Hib, HPV, MMR, MMRV, Meningococcal, Pneumococcal, Poliovirus, Rotavirus, and Varicella. In this bar graph, for each vaccination, the bars show the percentage change between 2019 and 2020. Each bar represents a single month. Most bars are below the zero line, representing declines in vaccination rates. The graph shows a steep decline in April and May for each vaccination, rebounding somewhat in June and July, with DTaP, Hib, MMRV, and Rotarivrus climbing above the zero line. A downward trend begins again in August for all vaccinations except Hib and MMR. The most significant declines in April and May 2020 were for TDaP, HPV, MMR, MMRV, and Meningococcal vaccinations. Also for these vaccinations, the data for August 2020 shows the most concerning downward trend after vaccination rates rebounded somewhat in June and July 2020. For all types of vaccinations, the vaccination rate in 2020 remains below the same period in 2019.

While our claims data has shown declines in preventive care services, the use of telehealth has dramatically increased, per Exhibit 10 below.

Exhibit 10: Telehealth Service Claims from January 2019 to August 2020

Please note exhibits include only a subset of FEHBP Health Plans

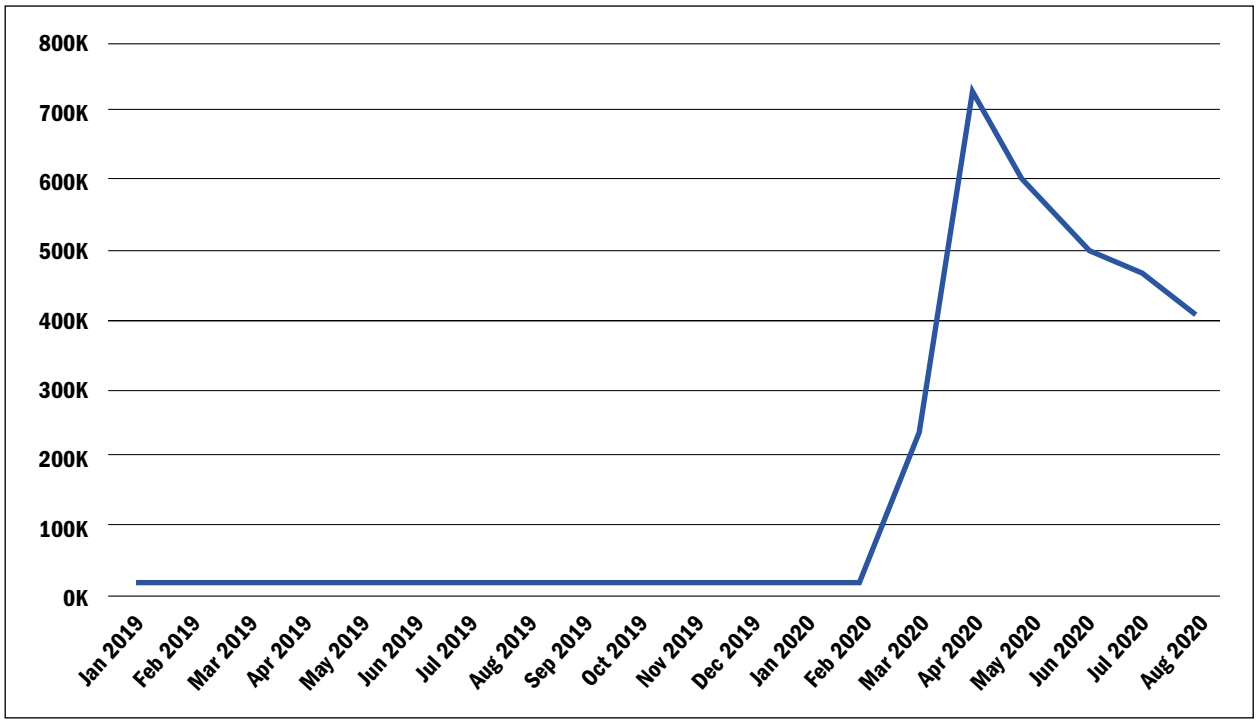


Exhibit 10: Telehealth Service Claims from January 2019 to August 2020. This line graph shows that in 2019, telehealth claims per month were stable and fairly low (below 20,000 a month). Starting in February 2020, consistent with the onset of COVID-19 in the U.S., telehealth claims per month rose dramatically, peaking in April 2020 above 700,000 and gradually falling back to just above 400,000 through August 2020. The number of claims in August 2020 were still far greater than the number of claims per month prior to COVID-19.

While it is encouraging that members of the analyzed FEHBP Health Plans are taking advantage of these services and thereby decreasing their risks of exposure to the virus, not all services can be provided via telehealth appointments. Members should be encouraged to use telehealth where possible while also making sure not to put off important preventive health procedures that must be performed in person, such as mammograms and vaccinations.

This increase in telehealth utilization will likely lead to future audit work by our office not only analyzing the potential cost savings, advantages, and disadvantages of telehealth services, but also ensuring that members and the FEHBP are protected from the potential for fraud and improper billing associated with this type of service.

MISSION STATEMENT

MISSION

To provide independent and objective oversight of OPM programs and operations.

VISION

Oversight through innovation.

CORE VALUES

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

OIG OFFICE LOCATIONS

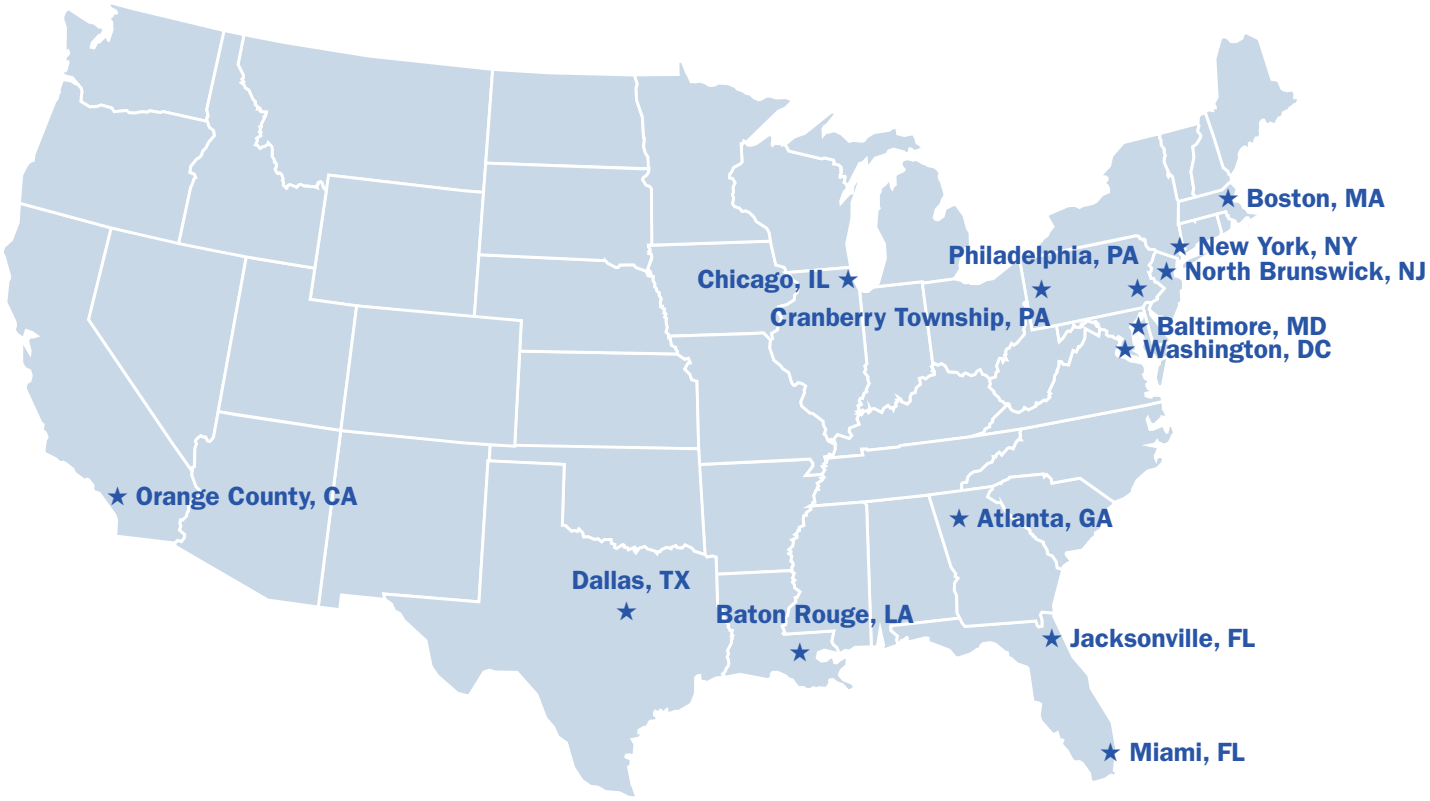


TABLE OF CONTENTS

AUDIT ACTIVITIES

Health Insurance Carrier Audits

The U.S. Office of Personnel Management (OPM) contracts with Federal Employees Health Benefits Program (FEHBP) carriers for health benefit plans for Federal employees, annuitants, and their eligible family members. 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 Office of the Inspector General (OIG) insurance audit universe encompasses over 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, non-renewal, and merger of participating health insurance carriers. Combined premium payments for the FEHBP total over $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 (BCBS) 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 may suffer a loss in certain situations if claims exceed amounts available in the Employee Health Benefits Fund, which is a fund in the U.S. Department of the Treasury (Treasury) that holds premiums paid by enrollees and from which carriers are reimbursed for claims paid and expenses incurred.

COMMUNITY-RATED PLANS

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

Similarly Sized Subscriber Group Audits

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

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

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

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

Medical Loss Ratio Audits

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

MLR 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 provide consumers with value for their premium payments.

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

The FEHBP-specific MLR requires carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must pay a subsidization penalty to OPM. Since the claims cost is a major factor in the MLR calculation, we are currently focusing our efforts on auditing the FEHBP claims used in the MLR calculation.

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

Capital Health Plan

Tallahassee, Florida
Report Number 1C-EA-00-19-024
May 13, 2020

Capital Health Plan (Plan) has participated in the FEHBP since 1986 and provides health benefits to FEHBP members in the Tallahassee, Florida area. The audit covered contract years 2014 through 2016. During this period, the FEHBP paid the Plan approximately $54.4 million in premiums.

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in overstated MLR credits totaling $480,183 for the three years audited.

Specifically, we found the Plan:

- Lacked adequate written policies and procedures governing its MLR process;
- Incorrectly reported its adjusted incurred claims in contract years 2014 through 2016;
- Improperly processed diabetic lancet and test strip claims as durable medical equipment;
- Used an unacceptable count method to calculate the Transitional Reinsurance Fee in contract years 2014 through 2016; and
- Incorrectly reported the Transitional Reinsurance Fee in the 2014 MLR filing due to its Medicare Primary membership.

AvMed

Gainesville, Florida
Report Number 1C-ML-00-19-019
May 18, 2020

AvMed (Plan) has participated in the FEHBP since 2003 and provides health benefits to FEHBP members in the South Florida area. The audit covered contract years 2013 and 2014. During this period, the FEHBP paid the Plan approximately $39 million in premiums.

We determined portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. The monetary impact of these issues was not significant enough to affect the 2013 and 2014 MLRs reported to OPM. However, if the identified issues are not addressed, they have the potential to affect the pricing and payment of FEHBP member claims and lead to incorrect reporting of the MLR in future years.

Specifically, we found the Plan:

- Had weak internal controls over portions of the FEHBP MLR reporting process;
- Inaccurately reported fraud reduction expenses and recoveries;
- Incorrectly calculated capitation expenses using a methodology that deviated from the Plan's own internal policies and did not adhere to the applicable criteria; and
- Had inadequate oversight to ensure the accuracy of the FEHBP claims processing and reporting used in the numerator of the MLR.

EXPERIENCE-RATED CARRIERS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan, 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 four final audit reports on experience-rated health plans participating in the FEHBP. These four final audit reports contained recommendations for the return of over $6.4 million to the OPM-administered trust fund.

Blue Cross Blue Shield Service Benefit Plan Audits

The BlueCross BlueShield Association (BCBS Association), on behalf of 64 participating plans offered by 36 BCBS companies, has entered into a Government-wide Service Benefit Plan contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBS Association delegates authority to participating local BCBS plans throughout the United States to underwrite and process the health benefit claims of its Federal subscribers. Over 60 percent of all FEHBP subscribers are enrolled in the BCBS Service Benefit Plan.

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management of the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the BCBS Association, BCBS plans, and OPM. The BCBS Association 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, D.C. These activities include acting as fiscal intermediary between the BCBS Association 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.

The following summaries of four recent BCBS audits are representative of our work.

Horizon BlueCross BlueShield of New Jersey

Newark, New Jersey
Report Number 1A-10-49-19-036
September 8, 2020

Our audit of the FEHBP operations at Horizon BCBS of New Jersey (Horizon) covered miscellaneous health benefit payments and credits (such as refunds, subrogation recoveries, and medical drug rebates), administrative expenses, cash management activities, and the plan's fraud and abuse program. We determined that Horizon did not return tax impact refunds to the FEHBP for ACA health insurance provider fees.

Throughout the audit process, we encountered numerous instances where Horizon was generally uncooperative during our audit, resulting in unacceptable delays in our audit process. This behavior was reported to OPM's Healthcare and Insurance Office (H&I) for consideration as a

factor impacting the plan's overall performance assessment rating and service charge calculation.

We questioned $5,456,848 in health benefit refunds and recoveries, medical drug rebates, administrative expense charges, cash management activities, and lost investment income. The BCBS Association and Horizon agreed with all of the questioned amounts.

CareFirst BlueCross BlueShield's Federal Employee Program Operations Center Costs

Owings Mills, Maryland and Washington, D.C.
Report Number 1A-10-92-20-002
September 10, 2020

Our audit of the FEHBP operations at CareFirst BCBS (Plan) covered the Plan's administrative expense charges for the FEP Operations Center. The objective of our audit was to determine whether CareFirst BCBS charged administrative expenses that were actual, allowable, necessary, and reasonable in accordance with the terms of Contract CS 1039 and applicable Federal regulations.

We questioned $7,877 in administrative expense charges and lost investment income, consisting of $7,594 for unallowable costs (e.g., lodging costs in excess of Federal per diem rates, alcoholic beverages, and gifts) and $283 for applicable lost investment income on these questioned charges. The BCBS Association and CareFirst BCBS agreed with these questioned amounts. As part of our review, we verified that CareFirst BCBS subsequently returned these questioned amounts to the FEHBP.

Overall, we concluded that the Plan's administrative expenses charged to the FEHBP for the FEP Operations Center were actual, allowable, necessary, and reasonable expenses incurred in accordance with the contract and applicable Federal regulations.

CareFirst BlueCross BlueShield

Owings Mills, Maryland
Report Number 1A-10-85-20-001
September 18, 2020

Our audit of the FEHBP operations at CareFirst BCBS (Plan) covered miscellaneous health benefit payments and credits (such as refunds and subrogation recoveries) and administrative expenses. We also reviewed the Plan's cash management activities and its fraud and abuse program.

We questioned $993,146 in administrative expense overcharges, cash management activities, and lost investment income. Our most significant finding was that the Plan held excess FEHBP funds totaling $954,919 in its FEP investment account because of overdraws from the FEHBP letter of credit account. The BCBS Association and the Plan agreed with all of the questioned amounts.

Supplemental Audit of Blue Cross and Blue Shield of Florida, Inc.'s Durable Medical Equipment, Home Health, and Home Infusion Benefits as Administered by CareCentrix

Jacksonville, Florida
Report Number 1A-10-41-17-011
April 3, 2020

The audit's objectives were to determine whether BCBS of Florida, Inc. (Plan) charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with OPM. Specifically, our objective was to determine whether the Plan's arrangement with CareCentrix Inc. (CareCentrix) complied with the contract provisions relative to health benefit payments.

Our supplemental audit found that CareCentrix performed both the duties of a carrier (i.e., setting up a provider network and coordinating with actual health care service providers) and of a

provider (i.e., submitting the claim for payment and accepting member payments), making it an entity that is between a carrier and a provider. As such, the Plan should only charge costs related to CareCentrix's provider services as a health care cost. All other carrier duties that CareCentrix performs should be charged as an administrative expense and should be subject to the Plan's administrative expense caps.

We reported that OPM, the BCBS Association, and the Plan incorrectly designated the CareCentrix contract as a provider contract, charging all of CareCentrix's costs, including those costs related to typical carrier activity normally reported as administrative expense, as part of the Plan's health benefit costs. In doing so, the Plan bypassed the administrative expense caps set up as part of the Service Benefit Plan requirements and potentially increased the member cost share on claims.

This final report included two procedural recommendations. However, after discussions with OPM regarding this issue, we have come to better understand that the current regulatory framework may not be consistent with how the health care industry has evolved over time. We have agreed to accept OPM's position on this issue and close the recommendations, with the understanding that further discussions will need to be held to determine whether updated OPM regulations are needed in light of the current business environment in the health care industry. As of the time of this semiannual report, however, both recommendations remain open.

Global Audits

Global audits of BCBS plans are crosscutting reviews of specific issues we determine are likely to cause improper payments. These audits cover all 64 BCBS plans offered by the 36 participating BCBS companies.

We did not issue any global audit reports related to experience-rated health plans during this reporting period.

Employee Organization Plans

Employee organization plans fall into the category of experience-rated plans. These plans either operate or sponsor participating Federal health benefits plans. As fee-for-service plans, they allow members to obtain treatment through facilities or providers of their choice.

The largest employee organizations are Federal employee unions and associations. Some of the employee organizations that participate in the FEHBP include the American Postal Workers Union; the Association of Retirees of the Panama Canal Area; the Government Employees Health Association, Inc.; the National Association of Letter Carriers; the National Postal Mail Handlers Union; and the Special Agents Mutual Benefit Association.

We did not issue any audit reports of employee organization plans during this reporting period.

Experience-Rated Comprehensive Medical Plans

Comprehensive medical plans fall into one of two categories: community-rated or experience-rated. As previously explained in this report, the key difference between the categories stems from how premium rates are calculated.

We did not issue any experience-rated comprehensive medical plan audit reports during this reporting period.

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems support the processing of retirement claims and multiple Government-wide human resources services. Private health insurance carriers participating in the FEHBP rely upon their own information systems to administer health benefits to millions of current and former Federal employees and their dependents. In addition, although the Defense Counterintelligence and Security Agency (DCSA) now administers the background investigations program for the Federal Government, OPM continued to operate the systems to support this program in FY 2020. Beginning in FY 2021, OPM will provide continued IT and network support to DCSA in implementing this vital mission. The ever-increasing frequency and sophistication of cyberattacks on both the private and public sector make the implementation and maintenance of mature cybersecurity programs a critical need for OPM and its contractors. Our information technology (IT) audits identify potential weaknesses in the auditee's cybersecurity posture and provide tangible strategies to rectify and/or mitigate those weaknesses. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the health insurance carrier, the sensitivity of the information in the system, the time elapsed since the last audit, and our previous audit results.

Our audit universe encompasses all 49 OPM-owned information systems and the 74 information systems used by private sector entities that contract with OPM to process Federal data. We issued four IT system audit reports during the reporting period. Selected notable reports are summarized below.

Information Systems General Controls at GlobalHealth, Inc.

Oklahoma City, Oklahoma
Report Number 1C-IM-00-19-037
April 16, 2020

Our IT audit centered on the information systems used by GlobalHealth, Inc. (GlobalHealth) to process and store data related to medical encounters and insurance claims for FEHBP members. We determined that its IT security program is immature, specifically that it lacks foundational policies common in effective IT security programs and its technical security controls need to be improved. GlobalHealth is aware of many of its shortcomings and is actively working to correct its weaknesses, and there are several areas where GlobalHealth has already successfully implemented controls.

Information Technology Security Controls of the U.S. Office of Personnel Management's Electronic Official Personnel Folder System

Washington, D.C.
Report Number 4A-CI-00-20-007
June 30, 2020

We conducted a performance audit of OPM's Electronic Official Personnel Folder System (eOPF) to ensure that the system's security controls meet the standards established by the Federal Information Security Modernization Act (FISMA), the National Institute of Standards and Technology (NIST), the Federal Information System Controls Audit Manual, and OPM's Office of the Chief Information Officer (OCIO). Our audit of eOPF determined that:

The eOPF Authorization to Operate (ATO) was granted in July 2019 for three years. Nothing came to our attention to indicate that eOPF's ATO was inadequate.

- The eOPF Privacy Threshold Analysis from March 2020 accurately identified that a Privacy Impact Assessment (PIA) should be completed;
- The eOPF PIA has not had a documented review since September 2017;
- The eOPF Federal Information Processing Standards 199 accurately categorized the system as a "high" impact system;
- The eOPF System Security Plan was last updated in November 2019, adequately reflects the system's current state, and follows the required OCIO template;
- The Security Assessment Plan, Security Assessment Report, and Risk Assessment Table all accurately follow the appropriate templates and include all of the required sections for the documents;
- Continuous monitoring appears to be conducted in accordance with applicable policies and procedures;
- In April 2019, OPM moved the eOPF backup site from Macon, Georgia, to Boyers, Pennsylvania. However, the eOPF Contingency Plan has not been updated to reflect the move and a new Contingency Plan test has not been conducted;
- The eOPF Plan of Action and Milestones had 12 open weaknesses that were accurately identified and tracked; and
- The eOPF security controls tested appear to be in compliance with NIST SP 800-53, Revision 4.

The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology

Washington, D.C.
Report Number 4A-CI-00-20-009
September 18, 2020

In fiscal year (FY) 2018, the OIG reported a significant deficiency in OPM's security assessment and authorization process. While there was a valid Security Assessment and Authorization (Authorization) in place for almost every major IT system in the agency's system inventory, the quality of the work and supporting documentation was questionable. We performed this audit to evaluate the effectiveness of OPM's Authorization program.

We believe OPM has addressed the significant deficiency in its Authorization process as it has documentation for each system we observed. OPM has made improvements in the authorization process for systems since its FY 2016 Authorization sprint. While OPM has made positive efforts in improving its Authorization process as systems are reauthorized, OPM has not shown the ability to consistently perform routine continuous monitoring activities.

Our audit identified weaknesses in most OPM Authorization processes including categorizing high value assets, managing privacy, reviewing security plans, conducting security assessments, planning for contingencies, tracking security vulnerabilities, and performing continuous monitoring of security controls.

OPM CYBERSECURITY PROGRAM

In the FY 2019 Senate Appropriations Committee Financial Services and General Government Appropriations Bill Report, S. Rept. 115-281, the

Committee encouraged the OIG to include in its Semiannual Reports to Congress a discussion of OPM's:

- Efforts to improve and address cybersecurity challenges including steps taken to prevent, mitigate, and respond to data breaches involving sensitive personnel records and information;
- Cybersecurity policies and procedures in place, including policies and procedures relating to IT best practices such as data encryption, multi-factor authentication, and continuous monitoring;
- Oversight of contractors providing IT services; and
- Compliance with Government-wide initiatives to improve cybersecurity.[11] A discussion of these issues is below.

OPM's efforts to improve and address cybersecurity challenges

OPM has made significant improvements in its technical IT security environment since 2015, including two-factor authentication at the network level, data encryption, incident response, patch management, and an improved network architecture. However, OPM is still striving to define its IT enterprise architecture. Failure to have a defined IT enterprise architecture increases the risk that the agency's security processes, systems, and personnel are not aligned with the agency mission and strategic plan.

OPM has defined and communicated a data breach response plan and established a data breach response team. However, OPM does not currently conduct routine exercises to test the plan, which includes requirements for quarterly reviews and annual testing. Failure to test the plan could increase OPM's risk of a major data loss in the event of a security incident.

OPM's cybersecurity policies and procedures

OPM has implemented data encryption on data at rest and in transit for the agency's most sensitive systems.

OPM has enforced multi-factor authentication for non-privileged users for network and remote access using personal identity verification (PIV) cards. However, the agency has not configured multi-factor authentication for all major systems. Enforcing the use of PIV authentication for the network is not sufficient, as users or attackers that do gain access to the network can still access most OPM applications containing sensitive data with a simple username and password. If PIV authentication were put in place at the application level, an attacker would have extreme difficulty gaining unauthorized access to data without having physical possession of an authorized user's PIV card. OPM has noted that it cannot fully implement multi-factor authentication until its legacy systems are replaced with modern technology, because legacy systems generally do not support multi-factor authentication. This situation further demonstrates the importance of OPM's IT modernization program. We have discussed OPM's current IT modernization plans in other documents, most recently our FY 2021 Top Management Challenges report.

OPM has developed an information security continuous monitoring (ISCM) strategy that addresses the monitoring of security controls at the organization, business unit, and individual

[11] Financial Services and General Government Appropriations Bill Report, S. Rept. 115-281.

information system level. However, in practice, OPM is not consistently implementing its ISCM strategy and has not met its objective of providing stakeholders with sufficient information to evaluate risk, primarily because OPM has not fully staffed its information system security positions. In FY 2019, only 8 of OPM's 47 systems were subject to adequate security controls testing and monitoring. The FY 2020 FISMA audit will provide a current assessment of OPM's ISCM process. This will be discussed in a future semiannual report.

OPM's oversight of contractors providing IT services

OPM requires the same level of security compliance for contractor-operated systems as OPM internal systems with regard to security authorization, continuous monitoring, and disaster recovery plans and testing. OPM also requires contractors to participate in the agency's IT security awareness training before providing access to OPM systems. However, OPM has struggled with monitoring contractors' system access after it has been granted.

OPM's compliance with Government-wide initiatives to improve cybersecurity

OPM has implemented security tools associated with the Department of Homeland Security's (DHS) Continuous Diagnostics and Mitigation program to automate security of the agency's network, and OPM uses the DHS-trusted internet connection initiative to optimize the security of the agency's external network connections.

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Our auditors are also responsible for conducting or overseeing certain statutorily required audits, such as the annual audit of OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

The following summaries of two recent audits are representative of our work.

OPM's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies

Washington, D.C.
Report Number 4A-RS-00-18-035
April 2, 2020

Our auditors completed a performance audit analyzing the sources of improper payments used in determining OPM's improper payments rate, as reported in the FY 2017 Agency Financial Report, and identifying any other sources of improper payments that OPM could potentially include in its improper payments rate calculations. Since FY 2011, the OIG has annually conducted an audit of OPM's improper payments reporting in the Agency Financial Report or Performance and Accountability Report to determine compliance with the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA). During our audit of OPM's FY 2017 Improper Payments Reporting, we identified potential issues with the methodologies used by OPM to develop their improper payments rates.[12] As a result, this performance audit focused on analyzing the methodologies used by the FEHBP and Retirement Services (RS) programs.

The objective of our audit was to determine if OPM's improper payments rate methodologies for the FEHBP and RS included all reasonable sources.

We determined that the FEHBP and RS improper payments rate methodologies do not include all reasonable sources of improper payments. Specifically:

- OPM's FY 2017 FEHBP improper payments rate methodology is outdated. In addition, H&I could not support its assertion that including estimated improper payments in its rate methodology, as required, would be inappropriate;
- FEHBP Fraud, Waste, and Abuse Report data is not included in the improper payments calculation;
- RS should continue to periodically assess the potential benefits of using the Do Not Pay Portal to identify improper payments;
- RS has not regularly conducted its Over Age 90 projects and does not use historical results to project improper payments to the population for the years when no projects are performed;
- RS does not report payments for deceased annuitants identified during their annual Internal Revenue Service Form 1099-R reviews in its improper payments rate calculation, including payments made to deceased

[12] Audit of the U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting, Report Number 4A-CF-00-18-012, dated May 10, 2018.

annuitants where the reclamation process was initiated;

- RS's assertion that limitations prevent it from using data mining to identify improper payments is not documented; and
- RS did not complete an analysis of the cost effectiveness of potential corrective actions.

Fiscal Year 2019 Improper Payments Reporting

Washington, D.C.
Report Number 4A-CF-00-20-014
May 14, 2020

The OIG annually audits OPM's reporting of improper payments to assess compliance with the Improper Payments Information Act, as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the IPERIA, as well as implementing Office of Management and Budget (OMB) guidance. Compliance with IPERA requires agencies do the following:

- Publish an Agency Financial Report (AFR) or Performance and Accountability Report (PAR) for the most recent fiscal year and post that report and any accompanying materials required by OMB on the agency website;
- Conduct a program-specific risk assessment for each program or activity that conforms with Section 3321 of Title 31 of the United States Code (U.S.C.) (if required);
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment (if required);
- Publish programmatic corrective action plans in the AFR or PAR (if required);
- Publish, and is meeting,[13] annual reduction targets for each program assessed to be at risk and estimated for improper payments (if required and applicable); and
- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR or PAR.

Our audit found OPM complied with IPERA's six requirements for FY 2019. IPERIA includes additional reporting requirements, such as utilizing the Do Not Pay portal and approval for both the improper payments rates and reduction targets. We further determined that OPM is in compliance with IPERIA's additional reporting requirements. In addition, we identified one area where OPM can improve its internal controls over improper payments reporting. Specifically, since 2011, RS and H&I programs have not reviewed and updated their determination that a payment recapture audit program is not cost effective.

[13] Inspectors General determine compliance with reduction targets by determining the robustness and validity of the agency's sampling methodology, and examining point estimates, precision rates and confidence intervals.

Special Audits

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

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

Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that 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. Our staff also performs audits of tribal enrollments into the FEHBP, as well as audits of the Combined Federal Campaign (CFC) to ensure monies donated by Federal employees and annuitants are properly handled and disbursed to charities according to the designations of contributing employees and annuitants.

The following summaries highlight the results of three audits conducted on OPM benefit program carriers during this reporting period.

CareFirst BlueChoice's Pharmacy Operations as Administered by CVS Caremark

Scottsdale, Arizona
Report Number 1H-07-00-19-017
July 20, 2020

We completed a performance audit of CareFirst BlueChoice's (Carrier) pharmacy operations as administered by CVS Caremark (or PBM). Our audit consisted of a review of the administrative fees, claims pricing and eligibility, drug manufacturer rebates, the fraud and abuse program, and performance guarantees for FEHBP pharmacy operations from contract years 2014 through 2017. The objective of the audit was to determine if pharmacy benefit costs charged to the FEHBP and services provided to its members were in accordance with OPM Contract Number CS 2879 and applicable Federal regulations.

We determined that the PBM and the Carrier need to strengthen their procedures and controls related to pass-through pricing and performance guarantees.

Specifically, our audit identified the following deficiencies that require corrective action for all years under review:

- The PBM overcharged the FEHBP $4,743,399 by not providing pass-through pricing based on the actual acquisition cost of drugs filled by its mail-order warehouses and specialty pharmacies;
- The PBM overcharged the FEHBP $834,425 by not providing pass-through pricing at the value of the PBM's negotiated discounts with two retail pharmacies; and
- The Carrier did not allocate or credit $53,478 in penalties to the FEHBP due to the PBM not meeting its performance guarantees.

No other exceptions were identified from our reviews of the administrative fees, claims eligibility, drug manufacturer rebates, and fraud and abuse program.

Federal Employees' Group Life Insurance Program As Administered by Metropolitan Life Insurance Company

Oriskany, New York
Report Number 2A-II-00-18-054
July 20, 2020

The OIG completed a performance audit of the FEGLI Program as administered by the Metropolitan Life Insurance Company (MetLife) for FYs 2015 through 2018. The audit included reviews of MetLife's administrative expenses, cash management, claims processing, performance standards, and service charge for FEGLI operations. The objective of the audit was to determine whether the costs charged to FEGLI and services provided to its subscribers were in accordance with the terms of Contract Number 17000-G and Federal regulations.

Our audit identified one monetary finding related to administrative expenses and one procedural finding related to claims processing, as follows:

- Unallowable Administrative Expenses: MetLife overcharged the FEGLI Program by $96,765 in 2015 as a result of erroneously including costs for a prior period adjustment in its year-end Letter of Credit Account reconciliation process. In addition to returning $96,765 to the FEGLI Program, MetLife is responsible for returning $10,636 in lost investment income. MetLife credited these amounts to the FEGLI program; and
- Claims Processing Errors: We identified 8 claims out of a judgmental sample of 234 claims reviewed that MetLife processed without the required documentation or at an incorrect payment amount.

2017 Combined Federal Campaign

Madison, Wisconsin
Report Number 3A-CF-00-19-031
June 18, 2020

We completed a performance audit of the 2017 CFC, as administered by the Give Back Foundation. Our audit consisted of a review of the CFC's cash management, campaign expenses, charity applications, and Quality Assurance Surveillance Plan. The objective of the audit was to determine if the 2017 CFC complied with the terms of Contract Number OPM1616C0001 (Contract) and Federal regulations.

Our audit found that the Give Back Foundation's 2017 CFC operations complied with the terms of the contract and Federal regulations. However, our audit identified two findings related to OPM's administration of the 2017 CFC that require corrective actions, as follows:

- Our review of the campaign's cash management activities identified $176,490 in miscellaneous funds that remained in the 2017 CFC contributions account but should have been transferred to the CFC project charity fees account to offset future distribution fees; and
- Our review of the campaign's Quality Assurance Surveillance Plan identified several performance standards that were not measureable, were unable to be assessed, or did not have clear penalty amounts defined.

No exceptions were identified from our reviews of the campaign expenses and charity applications.

ENFORCEMENT ACTIVITIES

Investigative Activities

The Office of Investigations' mission is to protect Federal employees, annuitants, and their eligible beneficiaries from fraud, waste, abuse, and mismanagement in OPM programs. We pursue this mission by conducting criminal, civil, and administrative investigations related to OPM programs and operations.

OPM annually disburses more than $140 billion in benefits through the Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), FEHBP, and FEGLI, which are paid from OPM-administered trust funds amounting to over $1 trillion. These programs cover more than eight million current and retired Federal civilian employees and eligible family members. Our investigations safeguard OPM's financial and program integrity and protect those who rely on OPM programs.

The Office of Investigations prioritizes investigations into allegations of harm against those reliant on OPM programs, the substantial loss of taxpayer dollars, and agency program weaknesses that allow fraud, waste, and abuse.

In the current nationwide health crises caused by the COVID-19 pandemic and the opioid epidemic, many of our investigations involve bad actors attempting to harm or exploit Federal employees, retirees, and their families who use the FEHBP for health insurance coverage. In the future, we expect our traditional health care fraud investigations to be further affected by these ongoing health crises, with a potential rise in interconnected health care schemes. For example:

- Coronavirus-related schemes often involve fake COVID-19 testing and treatments, but ancillary schemes exploit the changed health care environment. These ancillary schemes may include cases involving mental health treatment and telemedicine; and
- Opioid-related schemes can involve drug manufacturers, marketers, prescribing physicians, patients, and treatment facilities. Considering the health risks that substance use disorder poses, many of these cases involve patient harm in addition to the theft or waste of taxpayer dollars.

Our criminal investigators operate throughout the United States, and we partner with Federal and State law enforcement agencies and U.S. Attorney offices as part of our nationwide law enforcement mission. In recent years, we have joined Federal task forces and partnerships involving the COVID-19 pandemic, the opioid crisis, and other nationwide law enforcement priorities. We work to build relationships with prosecutorial authorities at the Department of Justice (DOJ) to ensure OPM programs are represented in cases where there has been a loss of taxpayer dollars or harm to OPM program beneficiaries.

In its FY 2019 Agency Financial Report, OPM reported total improper payments exceeding

$339 million. The OIG has previously expressed concerns that the improper payment amount and improper payment rates for both the FEHBP and OPM-administered retirement programs are undercounted by current methodology. We continue to appreciate working with the agency to improve the counting of improper payments across OPM programs. These efforts further our shared goals of preventing, reducing and recovering improper payments, as well as protecting OPM programs from fraud, waste, and abuse.

During this 6-month reporting period, our Office of Investigations' efforts led to 22 arrests, 24 indictments and criminal informations, and 11 convictions. We also took part in actions that resulted in $12,532,192 in monetary recoveries to OPM-administered trust funds. Many of our investigations are conducted jointly with other law enforcement agencies, and we actively coordinate with DOJ and other Federal, State, and local law enforcement authorities. Criminal, civil, and administrative recoveries and fines returned to the General Fund of the Treasury totaled $623,495,531 as a result of these joint investigations. A statistical summary of the Office of Investigations' investigative activities and financial recoveries are included in the appendices of this report.

In the following sections, we provide an overview of our investigative priorities and observed trends in fraud, waste, and abuse. We also summarize cases representative of our Office of Investigations' diligent work to protect OPM beneficiaries, programs, and operations. To the extent that pending criminal matters are discussed herein, and unless otherwise explicitly stated, the crimes and charges are alleged and all defendants and parties are presumed innocent unless proven guilty in a court of law.

THE IMPACT OF COVID-19 ON THE FEHBP AND THE OIG'S OFFICE OF INVESTIGATIONS

The COVID-19 pandemic has created an extraordinary health crisis in the United States. The CDC reports that since the beginning of the pandemic, the United States has had more than 7,168,000 COVID-19 cases and more than 205,000 related deaths as of the end of the reporting period on September 30, 2020. During this crisis, lawbreakers have callously sought to exploit the pandemic. The nature of the pandemic as a rapidly developing and persistent health crisis creates many opportunities for fraud, waste, and abuse to affect the FEHBP. Additional deaths of Federal annuitants or survivor annuitants may potentially cause spikes in unreported annuitant deaths, a major driver of improper payments in the FERS and CSRS programs. The Office of Investigations remains diligent in its proactive work and investigations to reduce the harm to OPM beneficiaries and programs.

COVID-19's EFFECT ON OFFICE OF INVESTIGATIONS OPERATIONS

During this semiannual reporting period, we took steps to protect our staff from the risks of COVID-19. Our criminal investigators are at particular risk because they interact in potentially physical situations with the public to conduct interviews and execute search warrants and arrests. While still conducting investigative activities, we did so under strict policies to protect our staff. However, these policies slowed our investigative output for this semiannual reporting period.

Additionally, many of our stakeholders—including our partners in the judiciary and other law enforcement agencies – were affected by State and local stay-at-home orders and social distancing limitations. At this time, we do not believe any investigative outcomes were negatively affected. However, ongoing cases experienced delays. Our investigative statistics reflect these complications and are lower than previous semiannual reporting periods.

THE COVID-19 PANDEMIC EFFECT ON FRAUD, WASTE, AND ABUSE

Through fraudulent claims, testing schemes, and the peddling of fake cures, bad actors are harming Americans concerned for the health and well-being of themselves and their families during the COVID-19 pandemic. This includes current Federal employees, retirees, and their families who receive health insurance coverage through the FEHBP, such as some Federal first responders.

In addition to COVID-19's direct effect on the FEHBP and its novel fraud schemes, ramifications of the pandemic on the health care system are also shaping fraud schemes not directly involving COVID-19. For example, the increase in telehealth appointments necessary during various State stay-at-home orders and to maintain social distancing recommendations also created opportunities for fraud by bad actors. While certainly and positively allowing for greater access to health care throughout the pandemic, telehealth is a common potential avenue for health care fraud. We are performing constant analysis to protect FEHBP enrollees from these risks.

Because of the complex nature of health care fraud investigations, the Office of Investigations' current COVID-19-related investigations are ongoing.

THE OPIOID EPIDEMIC

Public health reports express concern that previous progress in responding to the opioid epidemic could further retreat because of the COVID-19 crisis, with considerable potential to further increase opioid and drug abuse-related harm and death in 2020 and 2021.[14] In addition to the immediate dangers of patient harm, this resurgent opioid and drug abuse crisis also has the potential to increase fraud, waste, and abuse affecting the FEHBP and OPM programs. The OIG is particularly concerned with trends and potential abuse related to opioid and drug treatment facilities, sober homes, and urinary drug testing—including the potential effects of COVID-19 on these types of frauds.

The Office of Investigations has continued its fundamental strategy of investigating and pursuing the many types of fraud, waste, and abuse caused by the opioid epidemic. We work nationwide with Federal, State, and local law enforcement partners on task forces and in cooperative investigations to protect FEHBP programs and beneficiaries from the dangers and costs of opioid-related fraud, waste, and abuse.

Through our law enforcement actions, we protect Federal employees, retirees, and their covered

[14] Marcelina Jasmine Silva, DO, Zakary Kelly, MBA, The Escalation of the Opioid Epidemic Due to COVID-19 and Resulting Lessons About Treatment Alternatives, AJMC (June 1, 2020), https://www.ajmc.com/journals/issue/2020/2020-vol26-n7/the-escalation-of-the-opioid-epidemic-due-to-covid19-and-resulting-lessons-about-treatment-alternatives.

family members by investigating opioid-related cases at every level of the crisis, including:

- **Manufacturing-Level Abuse:** Some drug manufacturers and pharmaceutical companies encourage the proliferation of drugs of abuse and attempt to exploit the health care system for financial gain, often at the risk of patient harm;
- **Prescriber-Level Abuse:** Unethical doctors prescribe opioids and other potentially abused drugs without establishing medical relationships, determining medical necessity, or following appropriate prescribing guidelines;
- **Patient-Level Abuse:** Patients doctor shop to maintain their addiction or to obtain medications that they then illegally sell to those suffering from addiction; and
- **Treatment-Level Abuse:** Disreputable sober homes and recovery centers exploit patients seeking treatment, often through unnecessary and inflated drug testing or the creation of sober homes that allow drug abuse, relapse, and patient harm.

In this semiannual report, we share the following cases representative of our opioid-related investigations:

Pennsylvania Doctor Sold Opioid Prescriptions and Prescribed Unapproved Medications

In February 2018, we received a request from the Federal Bureau of Investigations for FEHBP claims information related to a doctor potentially prescribing opioids in exchange for monetary kickbacks. The provider also allegedly ordered, and administered to patients, medications not approved by the U.S. Food and Drug Administration.

Between January 2014 and March 2018, the doctor imported cheaper, foreign medications that were unapproved for use. The FEHBP paid the provider more than $1.6 million. According to the DOJ, the provider falsely billed Federal health care benefit programs approximately $2.3 million and pocketed the profits.

The investigation also revealed a pill mill where the doctor prescribed abused controlled substances outside the usual course of medical practice and in exchange for cash. This included prescribing oxycodone to patients whose urine drug screen tests indicated the use of illicit drugs.

In December 2019, the doctor pled guilty in the U.S. District Court for the Eastern District of Pennsylvania to one count of health care fraud, one count of importation contrary to law, and two counts of distributing a controlled substance. On September 15, 2020, the doctor was sentenced to serve 1 day in prison and 12 months of probation. The court also ordered he pay $1.2 million in restitution, of which the FEHBP will receive $24,835. On September 23, 2020, the provider agreed to a civil settlement wherein he will pay $1.2 million to resolve civil and criminal liability. The FEHBP will receive $41,460 from that settlement.

Opioid Drug Manufacturer Agrees to $130 Million Settlement Over False Statements

In September 2018, we received a qui tam complaint alleging a major pharmaceutical company misbranded buprenorphine and naloxone, a drug combination approved for use by recovering opioid-use disorder patients to avoid or reduce withdrawal during treatment. On July 24, 2020, the company pled guilty to a one-count felony criminal information charging false

statements relating to health care matters. The company admitted to making false statements in a specific Risk Evaluation and Mitigation Strategy related to accidental pediatric exposure by sending false or misleading information.

The FEHBP paid more than $43 million in claims between January 2009 and March 2017 for the at-issue medication. On July 24, 2020, the pharmaceutical company entered into a settlement to pay $300 million to resolve civil allegations. The total single damages for the settlement exceed $130 million. The single damages attributable to the FEHBP are $2.7 million.

OFFICE OF INVESTIGATIONS HEALTH CARE INVESTIGATIONS

The FEHBP is the largest employer-sponsored health insurance program in the world, covering about 8.2 million Federal current civilian employees, retirees, and their eligible family members. The program receives overall positive ratings from enrollees for program satisfaction in its annual member surveys. However, the program is susceptible to fraud, waste, and abuse—both from programmatic weaknesses within the FEHBP and from the same fraud, waste, and abuse that affects the health care system at large. Approximately 80 percent of the criminal cases that the OIG investigates involve health care fraud.

In FY 2019, OPM made $54.94 million in identified improper payments through the FEHBP. Without oversight and the work of the Office of Investigations, both patients and the financial integrity of the FEHBP program are at risk.

Health Care Fraud and Fraud Affecting the FEHBP

Beyond the immediate fraud schemes exploiting COVID-19, traditional health care fraud, waste, and abuse continues in manners both conventional and novel. In some respects, the changed health care landscape has infected more traditional health care fraud schemes with new facets. The Office of Investigations is particularly monitoring areas where health care fraud schemes may be intensified by the COVID-19 crisis or by prolonged changes to the health care environment, such as telemedicine. While the expansion of telemedicine has been a timely and important development for people to receive health care during the COVID-19 pandemic, it is an area potentially rife with fraud.

Because of the effects of the COVID-19 pandemic on our traditional criminal investigations, our investigative statistics during this semiannual reporting emphasize the various ways the Office of Investigations protects OPM programs and beneficiaries. While not all investigations result in criminal prosecutions, they require investigative work from our criminal investigators and investigative analysts to support U.S. Attorney's Offices and otherwise ensure that the FEHBP has an opportunity to recover funds in settlements and through other measures such as contract offsets. However, at times these investigations can be negatively affected by our exclusion from the Federal Anti-Kickback Statute. Please see the later section, The Anti-Kickback Statute: A Barrier to Investigations, for more details on this issue.

In this reporting period, we report health care fraud that fits familiar patterns that the Office of Investigations has observed in the past few years, including ineligible FEHBP beneficiaries and

schemes to increase reimbursement that risked harm to patients in the chase for profit.

Government Health Programs Targeted in Nationwide Mental Health Fraud Scheme

In March 2017, qui tam complaints filed nationwide alleged that a mental health provider defrauded Government health programs by pressuring psychiatrists to keep patients admitted on inpatient care for the maximum duration that a third-party payor authorized, even when medical professionals determined that the inpatient care or residential treatment was no longer medically necessary or beneficial to the patient. According to court documents, the mental health provider specifically targeted patients covered by Government third-party payors because these payors were assumed less likely to question the need for treatment.

Our investigation found the mental health provider engaged in fraudulent actions to submit false claims for inpatient behavioral health services provided to Government health program beneficiaries, including FEHBP beneficiaries. This included admission of ineligible beneficiaries for residential or inpatient treatment, improper and excessive lengths of stay, failures to provide inadequate staffing, and billing for services not rendered.

The mental health provider also improperly used physical and chemical restraints.

Between 2006 and 2018, the FEHBP paid more than $1.67 million in medical claims to this provider.

On July 15, 2020, DOJ entered into a civil settlement with the provider. The provider will pay $117 million to resolve civil liability related to the allegations. As part of the settlement, the FEHBP will receive $1.155 million in restitution.

Federal Employee Fakes Marriage for FEHBP Coverage

In October 2018, our OPM OIG Hotline received information alleging a Federal employee at the Federal Highway Administration (FHWA), U.S. Department of Transportation, fraudulently enrolled two ineligible beneficiaries for health insurance coverage on his FEHBP health insurance plan.

This FHWA employee listed two ineligible beneficiaries on his FEHBP, one as his wife and one as his stepchild, in January 2005. The FEHBP paid medical claims of $108,411 on behalf of the ineligible members, as well as the Government's portion of premiums on Family coverage, instead of Self-Only coverage. That was an additional loss of $43,248.

In all, the fraud scheme cost $151,660 in improper payments.

According to court records, when asked to provide a marriage certificate, the FHWA employee lied about difficulties obtaining a marriage certificate from the clerk in Las Vegas, Nevada. There was in fact no marriage certificate.

On May 18, 2020, a criminal information was filed charging a violation of 18 U.S.C. Section 1347, health care fraud, in the U.S. District Court for the Southern District of West Virginia against the Federal employee. On June 10, 2020, the Federal employee pled guilty to the charge. Sentencing is scheduled for October 2020.

New York Cardiologist Agrees to $2 Million Settlement for False Claims Act Violations

In March 2015, we received a qui tam complaint that alleged a medical provider submitted claims for services not medically needed. The

provider, a cardiologist, also paid kickbacks to other physicians for referrals of patients insured by Medicare, Medicaid, and the FEHBP. These referrals violated the False Claims Act and the Anti-Kickback Statute.

Falsified records were used to justify cardiac procedures. The cardiologist also attempted to disguise compensation paid to other doctors as rent.

Under an August 7, 2020, settlement, the cardiologist will pay $2 million. The U.S. Government will receive $1.3 million, including $75,971 being returned to the FEHBP.

The FEHBP had paid $210,896 to this provider between January 2010 and December 2017.

The cardiologist was previously arrested in October 2017 trying to flee the country after being indicted in the U.S. District Court for the Eastern District of New York on violations of the Anti-Kickback Statute. In August 2018, he was sentenced to 34 months of incarceration, 3 years of supervised release, 100 hours of community service, and restitution of $217,364. The FEHBP received $17,024 in restitution.

Multiple Individuals Sentenced in California Telemedicine Scheme as Part of National Health Care Fraud Takedowns

In June 2015, we joined a joint Federal and State criminal investigation into a group of medical providers that included pharmacists, doctors, and marketers working together to defraud Government health programs, including the FEHBP. The FEHBP paid more than $4.2 million related to the scheme, and all together more than $50 million in false claims were submitted.

This scheme specifically involved two common areas of health care fraud: compounded medications and telemedicine. Individuals could seek prescriptions for medications without being examined by a physician. Most of the prescriptions came from marketers, not physicians.

This case was part of the National Health Care Fraud Takedown operations in 2016, 2017, and 2018, as well as the local California Central District's Health Care Fraud Takedown of 2019. From June 2016 to present, the investigative efforts have culminated in approximately 29 indictments or criminal informations.

During FY 2020, nine subjects were charged related to this scheme: eight pharmacists, pharmacy owners, or marketers and one medical doctor

On August 26, 2020, one individual was sentenced to 34 months in prison and ordered to pay $28 million in restitution. This individual had pled guilty to one count of health care fraud in June 2017. On August 31, 2020, the court sentenced a second individual to 1 day in prison and 21 months of home detention, and ordered payment of $3.1 million in restitution. A third individual was sentenced to 1 day in prison and 18 months of home detention, and ordered to pay $1.425 million.

The FEHBP will receive its specific restitution in upcoming sentencings. Multiple other individuals are currently awaiting trial or sentencing. Therefore, further judicial actions are anticipated in this case.

The Anti-Kickback Statute: A Barrier to our Investigations

The Office of Investigations continues to encounter a specific constraint to our investigations because

of the Federal Anti-Kickback Statute. The Anti-Kickback Statute excludes the FEHBP because of narrow interpretation of "Federal Health Care Program" as defined in 42 U.S.C. Section 1320a-7b(f). Assistant U.S. Attorneys regularly reject including OPM as a victim in cases presented by our criminal investigators where the FEHBP has experienced losses because the allegations hinge on the Anti-Kickback Statute and its problematic scope.

The Anti-Kickback Statute can even negatively affect cases successfully prosecuted. In the ordering and calculation of restitution, the court may not consider stolen or fraudulently paid FEHBP funds because of the Anti-Kickback Statute, even if the funds were improper payments or ill-gotten gains. While we may receive restitution under the False Claims Act or other damages, major losses may still not be recovered if other allegations fall under the Anti-Kickback Statute.

In this semiannual reporting period, we closed several investigations because we are excluded from the Anti-Kickback Statute. These closed investigations included:

- A case involving a medical provider who paid kickbacks to doctors to refer patients for surgical procedures. The FEHBP had paid more than $1.3 million to this provider; and
- A case involving a medical provider who waived copay obligations for out-of-network claims. Between 2014 and 2019, the FEHBP paid this provider $10.9 million.

RETIREMENT ANNUITY FRAUD INVESTIGATIONS

Through its CSRS and FERS programs, OPM provides benefits for nearly 2.7 million Federal retirees and survivor annuitants through more than $7.6 billion in monthly payments. Our Office of Investigations works to safeguard retirees and survivor annuitants reliant on these programs.

Common fraud, waste, and abuse affecting the CSRS and FERS programs involves crimes such as identity theft or Representative Payee fraud, as well as under- or overpayments. The financial harm perpetrated by those we investigate, to include Representative Payee fraud, can be a form of elder abuse.

During the COVID-19 crisis, it is vitally important Federal retirees and annuitants are able to receive their duly earned annuities. DOJ warnings about bad actors exploiting COVID-19 as part of identity theft schemes raise concerns about how Federal annuitants and survivor annuitants could be affected.

Our Investigative Support Operations group conducts proactive searches of the OPM retirement rolls in order to find improper payments and unreported annuitant deaths. In some instances, our investigations find improper payments that have lasted years and cost tens of thousands of dollars.

This six-month period also is the first complete semiannual reporting period where the Representative Payee Fraud Prevention Act of 2019 has been law. The bipartisan bill, signed by President Donald J. Trump on March 18, 2020, closed a loophole that inhibited prosecution of some Representative Payees who unlawfully used or stole annuity payments from Federal retirees or survivor annuitants. One case below demonstrates our successes in investigating these Representative Payees who take advantage of vulnerable FERS and CSRS enrollees, and we look forward to reporting more of these successes in future semiannual reports.

Daughter Steals $86,000 After Survivor Annuitant's Death

In September 2016, we received a fraud referral from the RS program office regarding the unreported February 2012 death of an OPM survivor annuitant. More than $86,000 was improperly paid through October 2015.

Our investigation identified that the daughter of the survivor annuitant, along with the daughter's estranged husband, had stolen the survivor annuity. In August 2018, the daughter was indicted in the U.S. District Court for the District of Maryland for aiding and abetting and aggravated identity theft, which carries a two-year mandatory minimum sentence.

In May 2019, the estranged husband was also indicted in the U.S. District Court for the District of Maryland for theft of Government property, aiding and abetting, and conspiracy. A report in the National Crime Information Center also found that he had an active warrant in Virginia for larceny and failure to provide a court-ordered DNA sample.

On September 8, 2020, the husband pled guilty to theft of Government property. Further judicial action is expected in this case.

Representative Payee Charged For Stealing From Disabled Federal Annuitant

In July 2018, we received information from a Federal law enforcement partner about a Representative Payee allegedly stealing the OPM-issued annuity from a disabled Federal annuitant. This individual, a trusted Representative Payee for the U.S. Department of Veterans Affairs, took advantage of a CSRS annuitant suffering from mental illness, including short-term memory loss, who was unable to notice or report the theft and for whom the annuity was necessary to maintain quality of life.

The Representative Payee gained access to the funds of the OPM annuitant and others. Using at least 12 bank accounts, he stole funds from annuitants and other Federal benefits beneficiaries unable to protect themselves from his scheme. Per court documents, the Representative Payee diverted at least $139,942 in Government funds. This included $32,225 in OPM-issued annuities.

On July 7, 2020, the Representative Payee was charged by criminal information filed in the U.S. District Court for the District of Minnesota and pled guilty to wire fraud.

Our involvement in this case was made possible in part by the Representative Payee Fraud Prevention Act of 2019, which Congress passed and the President signed on March 18, 2020. This law allows our Office of Investigations to better protect vulnerable annuitants in cases that involve criminal Representative Payees stealing funds and harming those they are supposed to help.

$360,000 in Improper Payments Linked to Deceased Annuitant's Daughter

In March 2018, we received a referral from the RS program office regarding an annuitant's December 2006 death that was not reported to OPM, resulting in $360,463 of improper payments.

Through the Treasury's reclamation process, $5,757 was recovered.

Our investigation identified that the deceased annuitant's daughter stole the annuity.

In December 2019, the annuitant's daughter was charged by information in the U.S. District Court for

the District of Colorado with theft of Government funds. In January 2020, the daughter pled guilty to the charge, and on July 16, 2020, she was sentenced to 8 months in prison and 36 months of supervised release. She was also ordered by the court to pay restitution of $429,454, of which OPM will receive $354,706.

INTEGRITY INVESTIGATIONS

Oversight is a fundamental purpose of the OIG. We conduct investigations into allegations of fraud, waste, abuse, or mismanagement by OPM employees or contractors or within OPM programs. These civil, criminal, and administrative investigations ensure the public can have full faith and confidence in the agency's execution of its public duties.

The Inspector General Act of 1978, as amended, (IG Act) requires us to report all integrity cases involving senior Government officials or whistleblower retaliation in our semiannual report. This semiannual reporting period, we report one investigation involving a senior Government official.

CFC Manager Displayed Lack of Candor in Investigation of PII Transfers

In April 2017, we received an anonymous complaint alleging that a CFC employee in OPM's Merit Systems Accountability and Compliance office used a personal cloud storage service to host and transmit Personally Identifiable Information (PII) to conduct Government business and used Government time and resources to operate a personal business.

The CFC employee claimed to our criminal investigators that the cloud storage service was used to transfer large files to an OPM contractor. These files contained PII. The employee claimed to have received approval from the OPM OCIO to use the program for sharing Government data and stated that other CFC staff knew the program was being used for Government business.

During our investigation, a senior CFC manager stated in interviews with our criminal investigators that the CFC employee used an unauthorized drop box to receive data from an OPM contractor. This use was not approved by the OPM IT Security or OPM Contracting offices. This senior CFC manager also claimed that no PII, sensitive, or classified information was released and that they were initially unaware that the CFC employee used the program. The senior CFC manager stated that after learning of its usage in the spring of 2017, they requested the unapproved service not be used.

However, our criminal investigators found that the senior CFC manager's statements were false and displayed a lack of candor. The senior CFC manager was aware as early as December 2016 that the unauthorized program was being used, but they did not pursue disciplinary or administrative actions against the CFC employee for using the unapproved service. Its use was never reported to the OPM OCIO. Furthermore, no one reported the transfer of PII to the OPM Cyber Solutions office as required by the OPM Information Security and Privacy Policy Handbook.

We were unable to substantiate the allegations that the CFC employee used Government resources and time to conduct personal business. However, our investigation determined the CFC employee did inappropriately use the cloud storage service without approval and transferred PII over this service. The CFC employee retired from Federal Government service in October 2017.

A second CFC employee also provided false statements and displayed a lack of candor in denying prior knowledge of the unapproved program being used.

We referred this case to the U.S. Attorney's Office for the District of Columbia's Fraud and Public Corruption Division on January 29 and August 21, 2018, but the case was declined for prosecution in lieu of administrative remedies available to OPM.

On June 1, 2020, we notified the Acting Director of OPM of our findings. At this time, we have not been notified of any action taken by the agency.

THE OIG HOTLINE

The OIG operates a Hotline that contributes to identifying fraud, waste, and abuse in OPM programs and operations. Those who report information to our Hotline can do so openly, anonymously, or confidentially. Reports made to the OIG Hotline can be made without fear of reprisal.

The OIG Hotline telephone number and mailing address are listed on our website at https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse, along with an online complaint form for reporting fraud, waste, and abuse. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans.

We receive OIG Hotline tips and information from the public, OPM employees and contractors, and others interested in reporting fraud, waste, and abuse within OPM or its programs and operations. The OIG Hotline also receives reports of FEHBP health care fraud or CSRS- and FERS-related annuity fraud. However, many of the contacts we receive on our OIG Hotline involve customer service issues for OPM programs.

Customer service issues, most of which are related to OPM-administered retirement programs, are referred to the relevant OPM program offices. This is an issue we have raised with OPM; we continue to work with the agency to ensure the OIG Hotline is focused on receiving reports of fraud, waste, and abuse.

We received 1,084 hotline inquiries during the reporting period, and closed 1,520.[15] The OIG Hotline Case Activity table located later in this report contains the summary of hotline activities received through telephone calls, emails, and letters.

[15] The number of hotlines closed includes hotlines received during previous reporting periods that were reviewed and closed during this reporting period.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (5 U.S.C. Section 8902a), we suspend or debar health care providers whose actions demonstrate they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were 36,412 active suspensions and debarments of 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 or revocations. Before debarring a provider, our office gives the provider prior notice and the opportunity to contest the sanction in an administrative proceeding.

Suspension has the same effect as a debarment, but it becomes effective upon issuance, without prior notice or process and remains in effect for a limited time period. 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, our office issued 442 administrative sanctions (including both suspensions and debarments) of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we responded to 2,327 sanctions-related inquiries.

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

- Administrative actions issued against health care providers by other Federal agencies;
- Cases referred by the OIG's Office of Investigations;
- Cases identified by our administrative sanctions team through systematic research and analysis of electronically available information about health care providers; and
- Referrals from other sources, including health insurance carriers and State regulatory and law enforcement agencies.

Administrative sanctions serve a protective function for the FEHBP, as well as the health and safety of Federal employees, annuitants, and their family members who obtain their health insurance coverage through the FEHBP.

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

Debarment of Five New York City Osteopathic Physicians and Four Entities Involved in Fentanyl Scheme

In May 2020, our office debarred five New York City Osteopathic physicians and four entities involved in a health care fraud scheme. This scheme involved bribery and kickback conspiracies from an Arizona-based pharmaceutical company in exchange for prescribing large volumes of Fentanyl, a highly addictive painkiller.

The pharmaceutical company manufactured, marketed and sold fentanyl spray. The company

selected these five physicians to serve as speakers in Manhattan, New York, at more than 300 programs between November 2012 and March 2016. These programs were supposed to educate other physicians about the fentanyl spray using a slide presentation produced by the pharmaceutical company. However, many of these programs were merely social gatherings with no educational presentation. In some instances, the physicians also received more than $100,000 annually in bribes and kickbacks from the pharmaceutical company in order to prescribe the fentanyl spray.

Our office debarred one of the five physicians for a period of seven years based on his January 2020 conviction for Conspiracy to Violate the Anti-Kickback Statute, 18 U.S.C. § 371. The U.S. District Court for the Southern District of New York, imposed a sentence that included 57 months of imprisonment, followed by supervised release for a period of 3 years. The court also ordered the physician to forfeit $68,400 received from speaking engagements that were part of the conspiracy.

Our office debarred the remaining four physicians involved based on Interim Consent Orders issued by the New York State Board for Professional Conduct (Board). For each doctor, the Interim Consent Orders remain in effect until an investigation by the Board is complete and it makes a determination. The Interim Consent Orders prohibit the physicians from practicing medicine in New York State, from practicing at locations based on their New York licenses and from further relying upon their New York medical licenses to exempt themselves from the licensure, certification, or other requirements set forth in statute or regulation. In addition, the physicians are required to report their medical licenses as inactive, to not reactivate or reregister the licenses at any time, and to comply with the "Requirements for Closing a Medical Practice Following an Agreement to Never Register/Never Practice."

Debarment of these four doctors is for an indefinite period of time pending the outcome of the Board's investigations of each physician. In addition, two of the five physicians owned or held a controlling interest in four entities: a hematology/oncology practice; an emergency medicine and rehabilitation practice; a medical spa offering various skin care services; and a financial services company. In May 2020, our office debarred the four entities based on the physicians' debarment. The entity debarments will run for a period coinciding with the debarment of the respective physician. This case was referred to us by our Office of Investigations.

Texas Physician Debarred After Suspension of Medical License

In June 2020, our office debarred a Texas rheumatologist after his license was suspended by the Massachusetts Board of Registration for Medicine (Board). He was indicted in the U.S. District Court for the Southern District of Texas for the following:

- Count 1, Conspiracy to Commit Health Care Fraud, 18 U.S.C. § 1349;
- Counts 2 – 6, Health Care Fraud, 18 U.S.C. §§ 1342, 1347; and
- Count 7, Conspiracy to Commit Money Laundering, 18 U.S.C. § 1956(h).

The Board determined the physician posed a serious threat to the health, safety, and welfare of the public. In addition, the Board accused him of fraudulently renewing his medical license by not

reporting disciplinary actions taken against him by the Texas Medical Board.

Court documents revealed he was involved in a $200 million scheme designed to induce doctors to steer lucrative patients, particularly those with high-reimbursing out-of-network private insurance, to a specific hospital to maximize profits. The physician would order a battery of fraudulent, repetitive, and excessive medical procedures on patients in order to increase revenues. He also tampered with medical records and laundered money to conceal the source of the funds he made from Medicare claims. The physician received $50 million in fraudulent claims as part of this conspiracy.

The physician was found guilty of 11 counts of health care fraud, conspiracy to commit health care fraud, and conspiracy to obstruct justice. Due to the COVID-19 pandemic, his sentencing has been delayed, so the debarment was based on the suspension of his license in Massachusetts.

Our debarment of the physician will remain in effect for an indefinite period pending the resolution of his medical license and outcome of his trial. This case was referred to our office by the BCBS Association.

New York Physician Debarred for Health Care Fraud

In June 2020, our office debarred a New York physician based on his conviction in the U.S. District Court for the Southern District of New York for the following:

- Count 1, Conspiracy to Distribute Narcotics, 21 U.S.C. § 846; and
- Counts 2–5, Distribution and Possession with Intent to Distribute a Controlled Substance, 21 U.S.C. § 841.

The physician, an internal medicine specialist, pled guilty to writing prescriptions for controlled substances in exchange for cash. Court documents revealed that from 2013 to 2018, he wrote hundreds of prescriptions for oxycodone and other controlled substances for patients without a legitimate medical purpose. He wrote these prescriptions for highly addictive substances without conducting any physical examinations or seeing patients in an examining room. On more than one occasion, he wrote prescriptions with multiple names for one individual.

The physician was sentenced to 36 months in prison, to be followed by 36 months of supervised release, and also received an order of forfeiture in the amount of $46,800.

Under the FEHBP's administrative sanctions statutory authority, convictions constitute a mandatory basis for debarment. Our office imposed a six-year term of debarment on the physician. This case was referred to us by the BCBS Association.

Pharmacy Owner Debarred After Conviction Involving Drug Diversion Scheme

In September 2020, our office debarred a pharmacy owner (provider) with a history of drug diversion based on his July 16, 2018, health care related convictions: conspiracy to commit mail fraud, mail fraud, and obstruction of justice. Aggravating factors and the court judgement imposed by the U.S. District Court for the Middle District of Tennessee led to our determination to debar the provider for a period of 23 years.

The provider owned, operated, and served as president of a pharmaceutical company that sold medication from unlicensed street dealers located in Miami, Florida, and New York, New York. Over a three-year period, the provider knowingly and willfully sold approximately four tons of diverted prescription drugs to small, independent pharmacies throughout the United States. The provider was routinely told by the head of sales that his company sold bottles of prescription medication that contained the wrong dosage, the wrong medicine, or Tic Tac candy instead of the prescribed medication. Nonetheless, the provider and a co-conspirator continued operations and even took measures to hide their scheme from the Food and Drug Administration, pharmacies, and patients. The provider's measures to conceal its illegal activities included:

- Changing warehouses;
- Using burner phones;
- Hiring private pilots to fly diverted drugs to Nashville, Tennessee;
- Creating two shell companies to serve as buffers between the street diverters and the pharmaceutical company;
- Instructing the pharmaceutical company employees to create false pedigrees and purchase orders to make it appear as though the drugs were obtained through legitimate means; and
- Submitting the falsified pedigrees and purchase orders to a Federal grand jury.

In addition, the provider disregarded safety measures and requirements by failing to discard expired medications and instead, returned expired medications to street diverters for a credit of future purchases. He purchased millions of dollars of deeply discounted prescription drugs from unlicensed suppliers without requiring or receiving proper documentation. Further, the provider took elaborate steps to conceal the origin of these drugs in order to evade the Prescription and Drug Marketing Act, along with other state laws regulating the wholesale distribution of prescriptions drugs to ensure patients receive safe, authentic medicines. The provider also failed to relinquish the pharmaceutical company's license in New Hampshire when confronted by the State's licensing board about problematic drugs.

It is estimated that the provider received just over $1.4 million in criminal proceeds as a result of his actions. The Court ordered the owner to forfeit interest in the criminal proceeds in addition to paying approximately $3.4 million in restitution. The pharmacy owner was sentenced to 20 years in prison, followed by 3 years of probation or supervised release.

Our office debarred the pharmacy owner for a period of 23 years. This case was referred to us by our Office of Investigations.

EVALUATION ACTIVITIES

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

The following evaluations were completed during this reporting period.

Evaluation of the Enhancements Made to the Retirement Services' Customer Service Function

Washington, D.C.
Report Number 4K-RS-00-19-018
May 4, 2020

We conducted this evaluation to follow up on the progress the OPM RS office has made to enhance its customer service function based on recommendations from our September 2016 evaluation report (Evaluation of Retirement Services' Customer Service Function, Report No. 4K-RS-00-16-023). The 2016 evaluation report assessed RS's administration of its customer service functions for CSRS and FERS in the following two areas: (1) Annuitants' access to RS's customer service specialists; and (2) RS's response time to inquiries received from annuitants.

Based on the results of this evaluation, we determined that RS has made a number of enhancements to its customer service function to include addressing the backlog of written inquiries with the development of two new processes which have helped to reduce the written correspondence backlog. In addition, RS has made improvements in annuitants' access to its customer service via a toll-free number. However, annuitants are still having trouble reaching a customer service specialist as there is still a large number of abandoned calls and busy signals.

We recommended that RS address the large number of abandoned calls and busy signals to further improve the annuitants' ability to reach a customer service specialist. RS management concurred with this recommendation and established a "War Room" to make assignments and monitor results–continuing efforts that will proceed in all areas to improve the overall customer service experience.

U.S. Office of Personnel Management's Physical Security Risk Assessment Process

Washington, D.C.
Report Number 4K-FS-00-20-012
May 26, 2020

Our analysts completed an evaluation of OPM's physical security risk assessment process. Within OPM, the Security Services office under the Facilities, Security, and Emergency Management group is responsible for providing a safe and secure environment for OPM's information, personnel, and

operations. The Security Services group manages OPM's physical security, information security, and insider threat programs, including physical access control, threat assessments, and applicable national, industrial, and communications security directives.

During our evaluation, we determined that Security Services needed to improve controls for monitoring OPM's physical security risk assessment results. Security Service staff did not record assessment results, such as the countermeasures recommended for facilities and the status of countermeasures, in its security assessment database. In addition, Security Services' management did not perform ongoing monitoring or separate quality control reviews to ensure program objectives are met.

We made two recommendations to improve controls for monitoring OPM's physical security risk assessment results. Security Services' management concurred with our findings and recommendations and took immediate corrective actions to address our concerns. Based on our analysis of the corrective actions taken, we consider both recommendations resolved and closed.

LEGAL AND LEGISLATIVE ACTIVITIES

Under the IG Act, 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 Office of Legal and Legislative Affairs discharges this statutory responsibility in several ways, including by providing advice to the Immediate Office of the IG and the 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 which address waste, fraud, and abuse against and within OPM.

The OIG continued to keep Congress fully and currently informed of OIG activities and issues affecting OPM programs and operations through briefings, meetings, and responses to Congressional inquiries. During this reporting period, the OPM OIG participated in eight briefings, including five bipartisan courtesy meetings with the OPM IG Nominee and members and staff of the U.S. Senate Committee on Homeland Security and Governmental Affairs.

Notification to Congress Regarding Agency Failure to Provide Timely Access to Records

The IG Act provides that the OPM OIG is authorized to have timely access to all OPM records, documents, or other materials related to OPM programs and operations. Additionally, the Consolidated Appropriations Act of 2020 (Act), P.L. 116-93, prohibits the use of appropriated funds to "deny an Inspector General . . . timely access to any records" and requires the OIG to notify Congress should the agency fail to comply with the Act.[16] During this reporting period, the OIG notified Congress of the agency's failure to provide timely access to records.

As detailed in the Congressional notification, for over two months, OPM engaged in a pattern of delay and non-responsiveness that culminated with the failure to produce the requested agency records by a second, agency-established deadline. Prior to the Congressional notification, the OIG reported the agency's failure to provide the requested documents to the OPM Acting Director. The OIG reviewed the facts with the Acting Director. Specifically, the OIG discussed how the initial deadline for agency records set by the OIG had lapsed, but stipulated that the OIG would accommodate the second deadline established by the agency. The OIG also informed the Acting Director that should the agency fail to meet the second deadline, the Act left the OIG with no discretion as to reporting the delay to Congress. The agency-set deadline lapsed, and we notified Congress.

Since the Congressional notification, the Acting Director sent an agency-wide email on improving consistent and transparent communications between OPM and the OIG. The Acting Director shared his support of the OIG with all OPM staff, and the OIG looks forward to continuing our

[16] Division C, Financial Services and General Government Appropriations Act, 2020, Title VI § 626, P.L. 116-93.

shared mission of improving the agency's efficiency and effectiveness, free of fraud, waste, and abuse.

COVID-19 Pandemic Response

The Pandemic Response Accountability Committee (PRAC) was established as a committee under the Council of the Inspectors General on Integrity and Efficiency (CIGIE) by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The CARES Act provides over $2 trillion in emergency Federal spending to address the economic impacts of COVID-19. The PRAC was established to ensure that funds intended to support those affected by the COVID-19 pandemic are used efficiently, effectively, and in accordance with the law.

During this reporting period, our office provided support to CIGIE and the PRAC as requested. Specifically, our Office of Legal and Legislative Affairs advised on legal issues related to standing up the PRAC, staffing, and legislation. The Office of Legal and Legislative Affairs, along with other OIG components, and the Deputy Inspector General Performing the Duties of the Inspector General, also participated on the PRAC's Healthcare Subgroup to address issues affecting the FEHBP. In addition to our work with CIGIE and the PRAC, the Office of Legal and Legislative Affairs provided advice to OIG program offices on numerous issues relating to employee safety, pay, privacy, and leave. Our office recognizes that we are facing unprecedented times and will continue to work with oversight partners on combatting fraud, waste, and mismanagement of emergency funding as well as related challenges posed by the COVID-19 pandemic.

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Investigative Actions and Recoveries:

Indictments and Criminal Informations	24
Arrests	22
Convictions	11
Criminal Complaints/Pre-Trial Diversion	5
Subjects Presented for Prosecution	137
Federal Venue	131
Criminal	44
Civil	87
State Venue	4
Local Venue	2
Expected Recovery Amount to OPM Programs	$12,532,192
Civil Judgments and Settlements	$10,382,372
Criminal Fines, Penalties, Assessments, and Forfeitures	$810,399
Administrative Recoveries	$1,339,421
Expected Recovery Amount for All Programs and Victims[17]	$623,495,531

Correction: In our previous Semiannual Report (October 1, 2020, through March 31, 2020), due to late reporting, we did not report several carrier settlements executed during that reporting period. These settlements totaled an additional $173,850 returned to OPM, increasing our return to OPM programs for that Semiannual Reporting period to $3,973,045.

[17] This figure represents criminal fines/penalties and civil judgments/settlements returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures, 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.

Investigative Administrative Actions:

FY 2020 Investigative Reports Issued[18] 1,011

Issued between October 1, 2019–March 31, 2020 565

Issued between April 1, 2020–September 30, 2020 446

Whistleblower Retaliation Allegations Substantiated 0

Cases Referred for Suspension and Debarment 8

Personnel Suspensions, Terminations, or Resignations 1

Referral to the OIG's Office of Audits 0

Referral to an OPM Program Office 0

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued 442

FEHBP Provider Debarment and Suspension Inquiries 2,327

FEHBP Debarments and Suspensions in Effect at the End of Reporting Period 36,845

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

OIG Investigative Case Activity

	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened	266	33	6	6	311
Investigations[19]	44	9	3	1	57
Complaints	222	24	3	5	254
Inquiries Opened	1,033	1	0	0	1,034
Referrals – FEHBP Carriers/ Program Office	871	1	0	0	872
Referrals – All Other Sources/Proactive	162	0	0	0	162
Cases Closed	407	31	20	7	465
Investigations	69	15	6	3	93
Complaints	338	16	14	4	372
Inquiries Closed[20]	1,199	1	0	0	1,200
Referrals – FEHBP Carriers/ Program Office	1,037	1	0	0	1,038
Referrals – All Other Sources/ Proactive	162	0	0	0	162
Cases In-Progress[21]	313	64	26	9	412
Investigations	132	31	4	3	170
Complaints	181	33	22	6	242
Inquiries In-Progress[22]	50	0	0	0	50
Referrals – FEHBP Carriers/ Program Office	49	0	0	0	49
Referrals – All Other Sources/ Proactive	1	0	0	0	1

[19] This includes complaints from this reporting period and previous reporting periods that were converted to investigations during this reporting period.

[20] "Cases closed" may have been opened in a previous reporting period.

[21] "Cases in progress" may have been opened in a previous reporting period.

[22] "Inquiries in progress" may have been opened in a previous reporting period.

OIG HOTLINE CASE ACTIVITIES

OIG HOTLINE CASES RECEIVED 1,084

Sources of OIG Hotline Cases Received

- Website 659
- Telephone 254
- Letter 57
- Email 114
- In-Person 0

By OPM Program Office

- Healthcare and Insurance 235
  - Customer Service 53
  - Healthcare Fraud, Waste, and Abuse Complaint 135
  - Other Healthcare and Insurance Issues 47
- Retirement Services 184
  - Customer Service 121
  - Retirement Services Program Fraud, Waste, and Abuse 22
  - Other Retirement Services Issues 41
- Other OPM Program Offices/Internal Matters 97
  - Customer Service 24
  - Other OPM Program/Internal Issues 9
  - Employee or Contractor Misconduct 64
- External Agency Issues (not OPM-related) 568

OIG HOTLINE CASES REVIEWED AND CLOSED[23] 1,520

Outcome of OIG Hotline Cases Closed

Referred to External Agencies. 76

Referred to OPM Program Office 376

Retirement Services 81

Healthcare and Insurance. 255

Other OPM Programs/Internal Matters 40

No Further Action. 1,064

Converted to a Case 4

OIG Hotline Cases Pending[24] 528

By OPM Program Office

Healthcare and Insurance. 111

Retirement Services 224

Other OPM Program Offices/Internal Matters. 27

External Agency Issues (not OPM related) 144

Undetermined 22

Correction: In our previous Semiannual Report (October 1, 2020, through March 31, 2020), we underreported information related to the OPM OIG Hotline. In that period, we received 1,187 hotline reports and closed 586 hotline reports.

[23] This includes hotlines from this reporting period and previous reporting period that were reviewed and closed during this Semiannual Reporting Period.

[24] This includes hotlines that may have been opened in a previous reporting period. Additionally, this includes hotline cases pending an OIG internal review or an agency response to a referral.

APPENDICES

APPENDIX I-A

Final Reports Issued
With Questioned Costs for Insurance Programs
April 1, 2020 – September 30, 2020

	Subject	Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	6	$92,850,570
B.	Reports issued during the reporting period with findings	5	$12,196,574
	Subtotals (A+B)	11	$105,047,144
C.	Reports for which a management decision was made during the reporting period:	7	$98,117,356
	1. Net disallowed costs	N/A	-$15,611,240
	a. Disallowed costs during the reporting period	N/A	$13,927,063[1]
	b. Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$29,538,303[2]
	2. Net allowed costs	N/A	$113,728,596
	a. Allowed costs during the reporting period	N/A	$84,190,293[3]
	b. Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$29,538,303
D.	Reports for which no management decision has been made by the end of the reporting period	4	$6,929,788
E.	Reports for which no management decision has been made within six months of issuance	2	$1,191,085

[1] Represents the management decision to support questioned costs and establish a receivable during the reporting period.

[2] 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. The receivable may have been set up in this period or previous reporting periods.

[3] 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

April 1, 2020 – September 30, 2020

	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 findings	1	$176,490
	Subtotals (A+B)	1	$176,490
C.	Reports for which a management decision was made during the reporting period:	1	$176,490
	1. Net disallowed costs	N/A	$176,490
	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 six months of issuance	0	$0

APPENDIX II

Resolution of Questioned Costs in Final Reports for Insurance Programs

April 1, 2020 – September 30, 2020

	Subject	Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$127,429,642
B.	Value of new audit recommendations issued during the reporting period	$12,196,574
	Subtotals (A+B)	$139,626,216
C.	Amounts recovered during the reporting period	$17,698,597
D.	Amounts allowed during the reporting period	$113,728,596
E.	Other adjustments	$0
	Subtotals (C+D+E)	$131,427,193
F.	Value of open recommendations at the end of the reporting period	$8,199,023

APPENDIX III

Final Reports Issued With Recommendations for Better Use of Funds

April 1, 2020 – September 30, 2020

	Subject	Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	1	$108,880,417
B.	Reports issued during the reporting period with findings	0	0
	Subtotals (A+B)	1	$108,880,417
C.	Reports for which a management decision was made during the reporting period:	0	0
D.	Reports for which no management decision has been made by the end of the reporting period	1	$108,880,417
E.	Reports for which no management decision has been made within six months of issuance	1	$108,880,417

APPENDIX IV

Insurance Audit Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued	Questioned Costs
1A-10-41-17-011	Supplemental Audit of Blue Cross and Blue Shield of Florida, Inc.'s Durable Medical Equipment, Home Health, and Home Infusion Benefits as Administered by CareCentrix in Jacksonville, Florida	April 3, 2020	$0
1C-GA-00-20-005	MVP Health Care in Schenectady, New York	April 30, 2020	$0
1C-EA-00-19-024	Capital Health Plan in Tallahassee, Florida	May 13, 2020	$0
1C-ML-00-19-019	AvMed in Gainesville, Florida	May 18, 2020	$0
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	$5,631,302
2A-II-00-18-054	Federal Employees' Group Life Insurance Program as Administered by the Metropolitan Life Insurance Company for Fiscal Years 2015 through 2018 in Oriskany, New York	July 20, 2020	$107,401
1C-F8-00-19-039	Kaiser Foundation Health Plan of Georgia, Inc. in Portland, Oregon, and Oakland, California	July 27, 2020	$0
1A-10-49-19-036	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey	September 8, 2020	$5,456,848
1A-10-92-20-002	CareFirst BlueCross BlueShield's Federal Employee Program Operations Center Costs in Owings Mills, Maryland, and Washington, D.C.	September 10, 2020	$7,877
1A-10-85-20-001	CareFirst BlueCross BlueShield in Owings Mills, Maryland	September 18, 2020	$993,146
TOTAL			**$12,196,574**

APPENDIX V

Internal Audit Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued
4A-RS-00-18-035	U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020
4A-CF-00-20-014	U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020

APPENDIX VI

Information Systems Audit Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued
1C-IM-00-19-037	Information Systems General Controls at GlobalHealth, Inc., in Oklahoma City, Oklahoma	April 16, 2020
4A-CI-00-20-007	Information Technology Security Controls of the U.S. Office of Personnel Management's Electronic Official Personnel Folder System Report in Washington, D.C.	June 30, 2020
1B-32-00-20-004	Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia	September 9, 2020
4A-CI-00-20-009	U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020

APPENDIX VII

Combined Federal Campaign Audit Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued
3A-CF-00-19-031	2017 Combined Federal Campaign in Madison,Wisconsin	June 18, 2020

APPENDIX VIII

Special Review Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued
4A-DO-00-20-041	Management Advisory Report – Delegation of Authority to Operate and Maintain the Theodore Roosevelt Federal Building and the Federal Executive Institute in Washington, D.C.	August 5, 2020

APPENDIX IX

Evaluation Reports Issued

April 1, 2020 – September 30, 2020

Report Number	Subject	Date Issued
4K-RS-00-19-018	Evaluation of the Enhancements Made to the Retirement Services' Customer Service Function in Washington, D.C.	May 4, 2020
4K-FS-00-20-012	U.S. Office of Personnel Management's Physical Security Risk Assessment Process in Washington, D.C.	May 26, 2020

APPENDIX X

Summary of Reports

More Than Six Months Old Pending Corrective Action As of September 30, 2020

Report Number	Subject	Date Issued	Recommendations	
			Open	Total
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, D.C.	September 23, 2008	2	19
4A-CF-00-08-025	The U.S. Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements in Washington, D.C.	November 14, 2008	1	6
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, D.C.	November 5, 2009	2	30
4A-CF-00-09-037	The U.S. Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statements in Washington, D.C.	November 13, 2009	1	5
4A-CF-00-10-015	The U.S. Office of Personnel Management's Fiscal Year 2010 Consolidated Financial Statements in Washington, D.C.	November 10, 2010	3	7
4A-CI-00-10-019	Federal Information Security Management Act for Fiscal Year 2010 in Washington, D.C.	November 10, 2010	2	41
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.	September 14, 2011	2	14
4A-CI-00-11-009	Federal Information Security Management Act for Fiscal Year 2011 in Washington, D.C.	November 9, 2011	2	29
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, D.C.	November 14, 2011	1	7
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, D.C.	November 5, 2012	3	18
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, D.C.	November 15, 2012	1	3
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013	4	16
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1	1

APPENDIX X

Summary of Reports

More Than Six Months Old Pending Corrective Action As of September 30, 2020

Report Number	Subject	Date Issued	Recommendations	
			Open	Total
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	3	4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	14	29
4K-RS-00-14-076	The Review of the U.S. Office of Personnel Management's Compliance with the Freedom of Information Act in Washington, D.C.	March 23, 2015	2	3
4A-CI-00-15-055	Flash Audit Alert – The U.S. Office of Personnel Management's Infrastructure Improvement Project in Washington, D.C.	June 17, 2015	1	2
4A-RI-00-15-019	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015	2	7
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	15	27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	4	5
1A-10-17-14-037	Health Care Service Corporation in Chicago, Illinois	November 19, 2015	1	16
4A-CF-00-16-026	The U.S. Office of Personnel Management's Fiscal Year 2015 Improper Payments Reporting in Washington, D.C.	May 11, 2016	1	6
4A-CI-00-16-037	Second Interim Status Report on the U.S. Office of Personnel Management's Infrastructure Improvement Project – Major IT Business Case in Washington, D.C.	May 18, 2016	2	2
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, D.C.	July 8, 2016	4	6
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	4	4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	20	26
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	13	19
4A-RS-00-16-035	Information Security Controls of the U.S. Office of Personnel Managements Federal Annuity Claims Expert System in Washington, D.C.	November 21, 2016	2	13
4A-CF-00-17-012	The U.S. Office of Personnel Management's Fiscal Year 2016 Improper Payments Reporting in Washington, D.C.	May 11, 2017	1	10
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	4	4
4A-00-00-16-046	The U.S. Office of Personnel Management's Purchase Card Program in Washington, D.C.	July 7, 2017	1	12

APPENDIX X

Summary of Reports

More Than Six Months Old Pending Corrective Action As of September 30, 2020

Report Number	Subject	Date Issued	Recommendations	
			Open	Total
4A-CF-00-17-044	Information Technology Security Controls of the U.S. Office of Personnel Management's Federal Financial System in Washington, D.C.	September 29, 2017	1	9
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	8	8
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	36	39
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	17	18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	19	21
4A-CI-00-18-022	Management Advisory Report – the U.S. Office of Personnel Management's Fiscal Year 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018	2	4
4K-RS-00-17-039	The U.S. Office of Personnel Management's Retirement Services' Imaging Operations in Washington, D.C.	March 14, 2018	1	3
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5	5
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1	2
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018	2	4
4A-CI-00-18-044	Management Advisory Report – U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, D.C.	June 20, 2018	2	2
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	44	52
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, D.C.	November 15, 2018	20	23
4K-CI-00-18-009	The U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, D.C.	December 21, 2018	1	3
4A-CI-00-18-037	The U.S. Office of Personnel Management's Compliance with the Federal Information Technology Acquisition Reform Act in Washington, D.C.	April 25, 2019	5	5
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, D.C.	June 3, 2019	3	4
4A-HR-00-19-034	Independent Certified Public Accountants on the U.S. Office of Personnel Management Human Resources Solutions' Schedule of Assets and Liabilities in Washington, D.C.	June 6, 2019	3	4

APPENDIX X

Summary of Reports

More Than Six Months Old Pending Corrective Action As of September 30, 2020

Report Number	Subject	Date Issued	Recommendations	
			Open	Total
4A-IS-00-19-035	Independent Certified Public Accountants on the U.S. Office of Personnel Management National Background Investigations Bureau's Details of Analysis and Assumptions Schedule in Washington, D.C.	June 6, 2019	5	5
4A-CI-00-19-006	Information Technology Security Controls of the U.S. Office of Personnel Management's Enterprise Human Resource Integration Data Warehouse in Washington, D.C.	June 17, 2019	4	13
4K-ES-00-18-041	Evaluation of the U.S. Office of Personnel Management's Employee Services' Senior Executive Service and Performance Management Office in Washington, D.C.	July 1, 2019	5	6
1G-LT-00-18-040	BENEFEDS as Administered by Long Term Care Partners, LLC, for Contract Years 2014 through 2016 in Portsmouth, New Hampshire	September 11, 2019	3	5
4A-CF-00-19-026	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	October 3, 2019	7	7
4A-00-00-18-006	The U.S. Office of Personnel Management's Oversight of ID Experts Monitoring and Identity Theft Services Contract in Washington, D.C.	October 11, 2019	2	6
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, D.C.	October 23, 2019	17	23
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	47	47
4A-CF-00-19-025	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act of 2014 in Washington, D.C.	November 6, 2019	2	2
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, D.C.	November 18, 2019	20	20
4K-ES-00-19-032	Evaluation of the Presidential Rank Awards Program in Washington, D.C.	January 17, 2020	4	4
1A-99-00-18-005	Claim Amounts Paid That Equaled or Exceeded Covered Charges at All Blue Cross and Blue Shield Plans in Washington, D.C.	March 13, 2020	1	6
1H-01-00-18-039	Management Advisory Report – Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	March 31, 2020	2	2

APPENDIX XI

Most Recent Peer Review Results

As of September 30, 2020

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

Subject	Date of Report	Result
System Review Report on the Audit Organization of the Office of Inspector General for the U.S. Office of Personnel Management (Issued by the U.S. Department of Commerce Office of Inspector General)	October 4, 2018	Pass[1]
System Review Report on the NASA Office of Inspector General Audit Organization (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	August 13, 2018	Pass
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Special Inspector General for Afghanistan Reconstruction (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	March 10, 2020	Compliant[2]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management (Issued by the Office of Inspector General, Corporation for National and Community Service)	December 2, 2016	Compliant[2]
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. Consumer Product Safety Commission, Office of Inspector General)	December 16, 2019	Compliant[3]
External Peer Review Report to Ensure the CIGIE Standards for Inspections and Evaluations were Followed by the Office of the Inspector General for the Corporation for Public Broadcasting (Issued by the Office of the Inspector General, U.S. Office of Personnel Management)	December 4, 2018	Compliant[3]

[1] A peer review rating of "Pass" is issued when the reviewing OIG concludes that the system of quality control for the reviewed OIG been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The Peer Review does not contain any deficiencies or significant deficiencies.

[2] A rating of "Compliant" conveys that the reviewed OIG has adequate internal safeguards and management procedures to ensure that the CIGIE 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 CIGIE standards for Inspections and Evaluations are followed.

APPENDIX XII

Investigative Recoveries

April 1, 2020 – September 30, 2020

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			$6,522,492	$1,339,421
	Healthcare & Insurance		$5,684,691	$501,620
		Carrier Settlements	$5,684,691	$501,620
	Retirement Services		$837,801	$837,801
		Administrative Debt Recoveries	$324,831	$324,831
		Identification of Improper Payments Referred to Program Office	$41,047 $471,924	$41,047 $471,924
Civil			$557,967,342	$10,382,372
	Healthcare & Insurance		$557,967,342	$10,382,372
		Civil Actions	$557,967,342	$10,382,372
Criminal			$59,005,697	$810,399
	Healthcare & Insurance		$58,576,242	$455,692
		Court Assessments/Fees	$2,549	$0
		Criminal Fines	$15,000	$0
		Criminal Judgments/Restitution	$58,576,242	$455,692
	Retirement Services		$429,454	$354,706
		Criminal Judgments/Restitution	$429,454	$354,706
Grand Total			$623,495,531	$12,532,192

INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)

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November 2020
OIG SAR 63