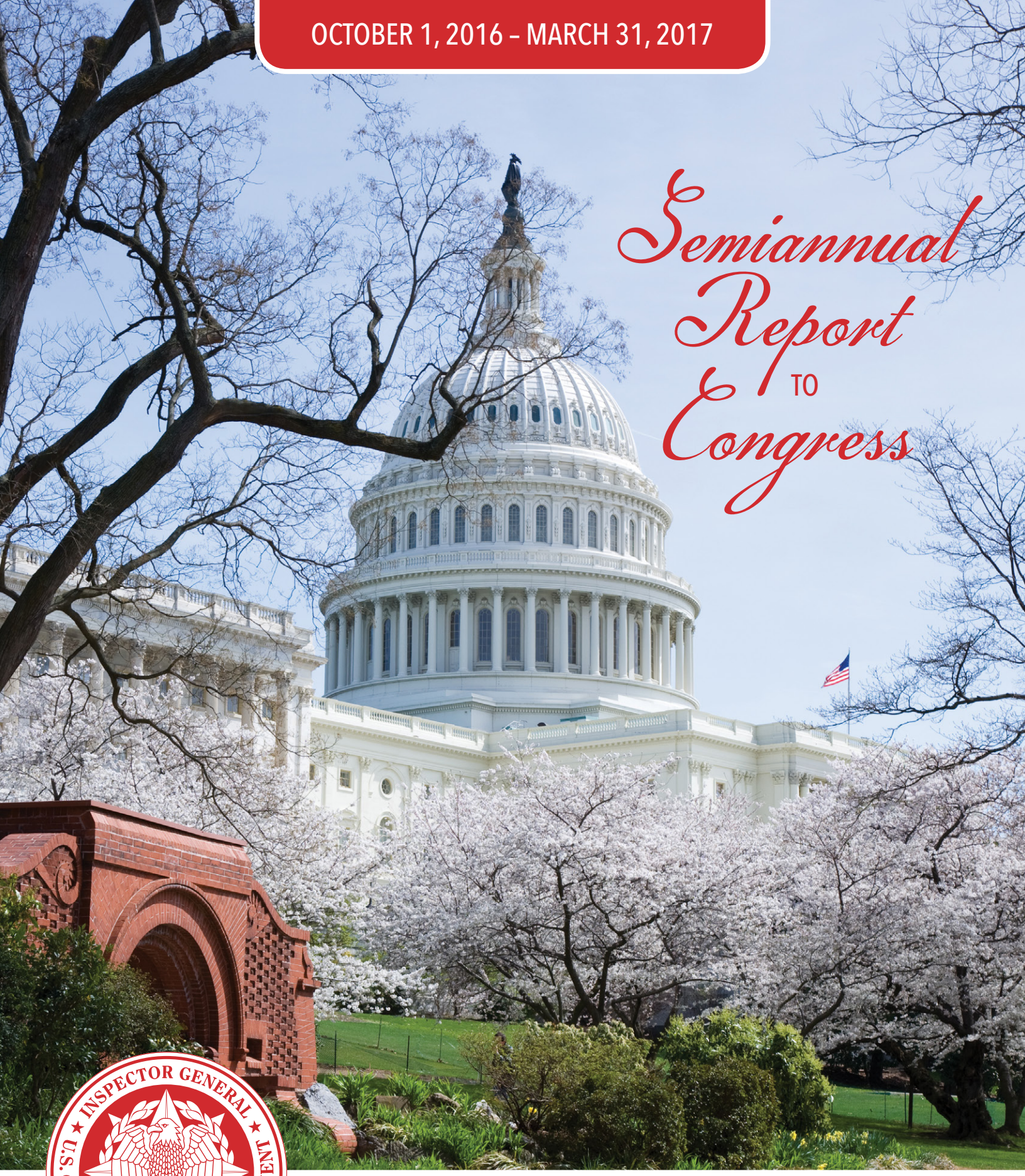
OCTOBER 1, 2016 – MARCH 31, 2017



Semiannual Report to Congress

United States Office of Personnel Management

OFFICE OF THE INSPECTOR GENERAL

OFFICE OF THE INSPECTOR GENERAL

Indicators

Financial Impact:

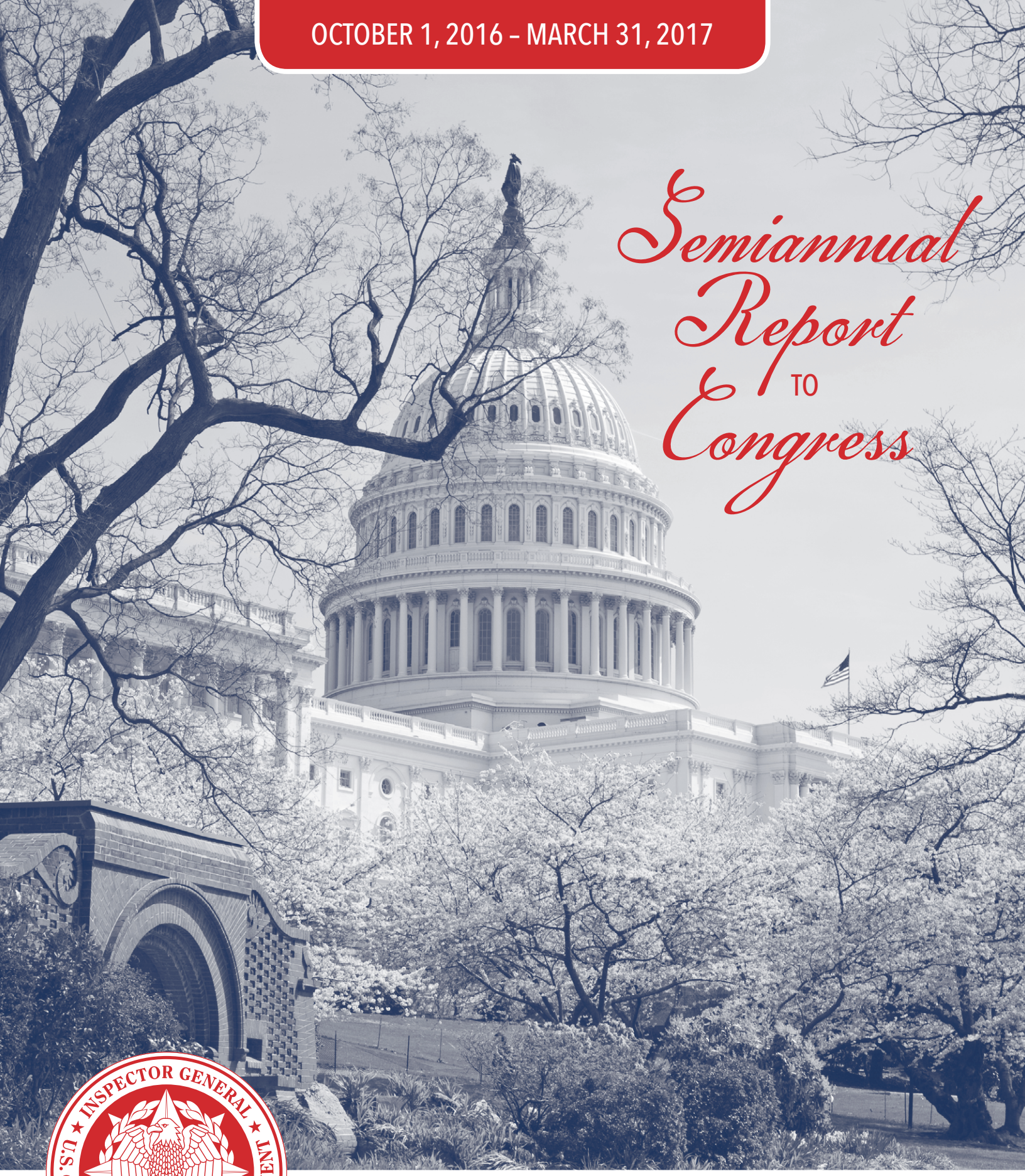
Audit Recommendations for Recovery of Funds	$42,469,336
Management Commitments to Recover Funds	$6,818,931
Recoveries Through Investigative Actions	$4,578,116

Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting period audit recommendations.

Accomplishments:

Audit Reports Issued	22
Special Review Reports Issued	3
Investigative Cases Closed	65
Indictments and Informations	54
Arrests	47
Convictions	30
Hotline Contacts and Complaints Received	1,190
Hotline Contacts and Complaints Closed.....	1,376
Health Care Provider Debarments and Suspensions	383
Health Care Provider Debarment and Suspension Inquiries	2,228

OCTOBER 1, 2016 – MARCH 31, 2017



Semiannual Report to Congress

United States Office of Personnel Management

OFFICE OF THE INSPECTOR GENERAL

Message from the Acting Inspector General

Under current law, it is illegal for a doctor or health care provider to accept a kickback in exchange for making a medical referral, prescribing a medication, or making other medical decisions that would generate claims under a "Federal health care program," as defined in what is known as the Anti-Kickback Statute (42 U.S.C. § 1320a-7b). A kickback may take any number of forms, including cash, trips, gifts, employment (such as sham consulting positions), free services, etc. Criminal and/or civil prosecution of violations may result in fines, exclusion from future participation in Federal programs, and imprisonment.

The logic behind this prohibition is unequivocal: doctors should not be thinking about profit when they are considering whether a patient needs bloodwork, what medication to prescribe, or whether surgery is necessary. By introducing a financial incentive into physicians' decision-making processes, kickbacks can lead to unnecessary treatment, increased costs, and patient harm.

The Anti-Kickback Statute, however, has a giant loophole that puts the health and wellbeing of more than eight million people at risk: the Federal Employees Health Benefits Program (FEHBP) administered by the U.S. Office of Personnel Management (OPM). The FEHBP, which covers Federal employees, retirees, and their families and which receives nearly three-quarters of its funding from Federal coffers, is explicitly excluded from the statutory definition of "Federal health care program." Therefore, while it is illegal for a doctor to accept a bribe when designing the treatment plan of a Medicare, Medicaid, or Tricare enrollee, such conduct is permitted if the patient is enrolled in the FEHBP.

The FEHBP's exclusion from the Anti-Kickback Statute appears to be the consequence of a misunderstanding of the program's makeup. In 1996, Congress was reexamining the statute, which at that time applied only to Medicare and State health care programs, including Medicaid. Federal legislators wanted to extend kickback protection to other Federal health care programs that could be vulnerable to kickback fraud, namely those that operated on a "fee-for-service" or "experience-rated" model. The legislative history indicates Congress

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concluded that the FEHBP did not need to be covered under the statute because there were more health maintenance organizations (HMOs) in the program than fee-for-service plans. The underlying rationale for this determination was that under a traditional HMO model, referrals are made to doctors employed or under contract with the HMO, and prescriptions are filled by the HMO-owned pharmacies, negating any financial incentives for unnecessary medical treatment. When drafting the legislation, Congress was not cognizant that in 1996 HMOs accounted for only 26 percent of FEHBP enrollees. The overwhelming majority of FEHBP enrollees – 74 percent – were actually in the very same fee-for-service plans that Congress believed needed protection, and in fact the percentage of FEHBP beneficiaries enrolled in fee-for-service plans has increased since then, accounting in 2016 for roughly 87 percent of total enrollment.

The FEHBP's exclusion from the Anti-Kickback Statute has been a continuing source of frustration for our office. Kickback cases involve claims for medically unnecessary services (since the doctor made the referral or prescribed the medication not because the patient needed it, but because of the kickback), and we are generally able to recover payment for medically unnecessary claims on behalf of the FEHBP. However, we are repeatedly excluded from major investigations and settlements because of the program's exclusion from the Anti-Kickback Statute.

For example, in January 2017, the U.S. Department of Justice announced a $350 million settlement with Shire Pharmaceuticals LLC and other subsidiaries of Shire plc. The settlement resolved allegations that these companies unlawfully paid kickbacks to induce clinics and physicians to use Dermagraft, a bioengineered human skin substitute. The kickbacks included lavish dinners, alcoholic beverages, entertainment, travel, medical equipment, medical supplies, unwarranted payments for purported speaking engagement and bogus case studies, cash, credits, and rebates. To date, this settlement ranks as the largest False Claims Act recovery by the United States in a kickback case involving a medical device.

Our office first received a complaint concerning some of the settled allegations in April 2012, but closed it the same day because the FEHBP is excluded from the Anti-Kickback Statute. A subsequent complaint, received in February 2013, was pursued only because it included other allegations that were ultimately of limited consequence. In the end, OPM was left out of the restitution process due to the FEHBP's exclusion from the Anti-Kickback Statute, saddling taxpayers and FEHBP beneficiaries with the expense of millions of dollars in extra and medical claims that were the product of the kickback scheme.

As we enter the third decade of the FEHBP's exclusion from the Anti-Kickback Statute, I would like to assure all FEHBP enrollees that this office remains steadfastly committed to continue working with Congress to amend this provision so that we may more effectively pursue our statutory mission of rooting out fraud, waste, and abuse against OPM programs.

Norbert E. Vint
Acting Inspector General

Mission Statement

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

We accomplish our mission by:

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

Guiding Principles

We are committed to:

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

Strategic Objectives

The Office of the Inspector General will:

- Combat fraud, waste and abuse in programs administered by OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM complies with applicable Federal regulations, policies, and laws.
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws, and regulations.
- Aggressively pursue the prosecution of illegal violations affecting OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.

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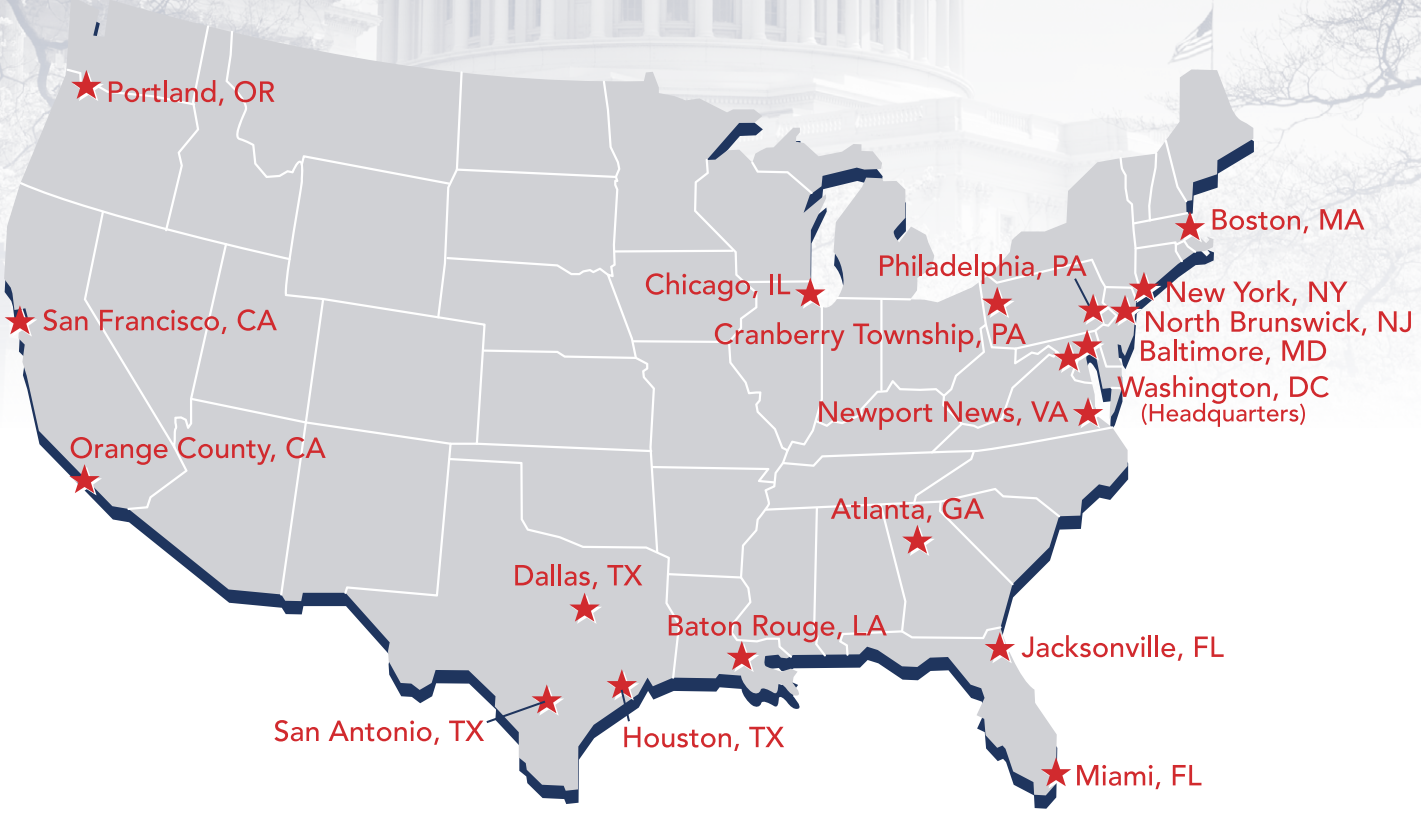

Audit Activities

Health Insurance Carrier Audits

The United States Office of Personnel Management (OPM) contracts with private sector firms to provide health insurance through the Federal Employees Health Benefits Program (FEHBP), as well as through the marketplaces under the Affordable Care Act. Our office is responsible for auditing the activities of these programs to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 275 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or health insurance carrier mergers and acquisitions. The premium payments for these health insurance programs are over $50 billion annually.

The health insurance plans that our office audits are either community-rated or experience-rated carriers.

> ***Community-rated carriers*** *are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs) or health plans.*
>
> ***Experience-rated carriers*** *are mostly fee-for-service plans, the largest being the BlueCross and BlueShield health plans, but also include experience-rated HMOs.*

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

During the current reporting period, we issued 11 final audit reports on organizations participating in the FEHBP, of which 9 contain recommendations for monetary adjustments in the amount of $42.5 million due to the OPM-administered trust funds.

COMMUNITY-RATED PLANS

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

Similarly Sized Subscriber Group Audits

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

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

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

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

Medical Loss Ratio Audits

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

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

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

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

Multi-State Plan Program Audits

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

with MSP Program Issuers, including rates and benefits, in consultation with states and marketplaces. In addition, OPM monitors the performance of MSP Program Issuers and oversees compliance with legal requirements and contractual terms. OPM's office of National Healthcare Operations has overall responsibility for program administration. In 2017, the MSP Program universe consists of approximately 22 state-level issuers covering 22 states. Our audits of this program test the issuer's compliance with the provisions of its contract with OPM as well as with other applicable Federal regulations.

During this reporting period, we issued 6 final audit reports on community-rated health plans recommending approximately $16.7 million in recoveries. In addition, we issued one final report related to the MSP Program this reporting period. Report summaries are provided below to highlight notable audit findings.

Management Alert – Status of the Multi-State Plan Program

WASHINGTON, DC

Report No. 4A-HI-00-17-013

DECEMBER 8, 2016

The OIG issued a management alert letter to OPM to highlight and bring to their immediate attention the status of the MSP Program. Specifically, the letter identified the following challenges:

- The MSP Program is experiencing a reduction in the number of options offered by MSP Issuers. We expect this to continue until the market stabilizes;
- The MSP Program currently faces several challenges. Some of these challenges are specific to the program while others are related to the Patient Protection and Affordable Care Act (Affordable Care Act); and
- OPM's National Healthcare Operations (NHO) is doing the best that it can to attract and retain MSP Issuers and state-level issuers into the program. However, the program is voluntary and the Affordable Care Act does not provide OPM with the necessary authority to create attractive incentives that would encourage greater participation. For example, establishing requirements that are consistent for all states would significantly reduce the administrative burden and promote increased issuer involvement in the program. However, legislative changes would be required to allow for such flexibilities.

Based on these identified challenges, our letter recommended that NHO:

- Continue to pursue MSP Issuer and state-level issuer expansion to attempt to meet the regulatory requirement of coverage in all 50 states and the District of Columbia;
- Communicate and work with state-level issuers that have developed unique ways to differentiate their MSP options and be successful. These could then be shared with other state-level issuers to increase their chance at success; and,
- Clarify the "Multi-State Plan" nomenclature for the names of MSP options. There may be continued confusion for the consumer regarding marketplace plans labeled as "Multi-State" plans. The name, taken by itself, is misleading to the consumer as they may not fully understand the program's purpose.

OPM responded to this letter in December 2016 and was in general agreement with our recommendations, but expressed some concerns that the current volatility of the marketplace and the differences in the state exchanges could impact their ability to implement our recommendations. Consequently, the recommendations in this letter remain open.

Aetna Open Access – Capitol Region

BLUE BELL, PENNSYLVANIA

Report No. 1C-JN-00-16-019

JANUARY 31, 2017

The Aetna Open Access Plan – Capitol Region (Plan) has participated in the FEHBP since 1982, and provides health benefits to FEHBP members in Washington, D.C.; Northern, Central, and Southern Maryland; Northern and Central Virginia; and Richmond, Virginia. The audit covered the Plan's 2013 FEHBP premium rate build-up and MLR submission. During this period, the FEHBP paid the Plan approximately $587.6 million in premiums.

Our auditors questioned $16,169,511 for an MLR penalty underpayment in 2013. Specifically, we found that the Plan:

- Used "Direct Premiums Written" instead of "Direct Premiums Earned" to determine the large group premium ratio. "Direct Premiums Earned" more accurately represents the calendar year premium;
- Did not use a fair and equitable allocation method to derive the FEHBP's portion of Federal income tax expense;
- Overstated the medical claims, used to derive the 2013 MLR by including payments for non-covered benefits;
- Overstated the pharmacy claims adjustment credit used to derive the 2013 MLR, by including claim adjustments not applicable to the 2013 contract year; and,
- Finally, the audit recommended an area of program improvement to address concerns identified during the dependent eligibility review related to the documentation being maintained by the Plan to support overage dependent eligibility.

Errors in the 2013 MLR Calculation Result in a $16.2 Million Penalty Underpayment to OPM

Aetna agreed with the claim overpayments and the pharmacy claims adjustment credit and updated their MLR calculation accordingly. They also implemented a corrective action plan to address our program improvement area. However, Aetna does not agree with the use of "Direct Premiums Earned" as the basis for allocating expenses; even though, starting in 2014, they are moving to a new method of premium allocation that is more in line with the "Direct Premiums Earned" method. Aetna also disagrees with our finding regarding their income tax allocation methodology. As this particular issue will impact audits of other plans Aetna administers, it is crucial that OPM develop program guidance to more clearly define acceptable allocation methods.

QualChoice

LITTLE ROCK, ARKANSAS

Report No. 1C-DH-00-16-025

FEBRUARY 22, 2017

QualChoice (Plan) has participated in the FEHBP since 2010, and provides health benefits to FEHBP members in the State of Arkansas. The audit covered contract years 2011 and 2012. During this period, the FEHBP paid the Plan approximately $3.2 million in premiums.

In 2011 and 2012, we identified inappropriate health benefit charges to the FEHBP totaling $173,283 and $99,131, respectively. In addition, we determined the FEHBP is due $29,496 for lost investment income as a result of the overcharges. Our audit also showed that the Plan did not maintain original source documentation for various components of the rate developments, and it did not currently have fraud and abuse detection software in place to analyze claims data, as required under FEHBP Carrier Letters.

The questioned overcharges occurred because the Plan:

- Used incorrect loadings, copay values and factors and did not apply the largest SSSG discount when deriving the 2011 FEHBP rates; and
- Used incorrect factors, did not properly account for the grandfathering of our benefits, and did not apply the largest SSSG discount when deriving the 2012 FEHBP rates.

Non-compliance with the FEHBP Rules and Regulations Resulted in Program Overcharges of $301,910

QualChoice agreed with all of the audit findings and returned the questioned amount of $301,910 to OPM in March 2017. However, the audit is still open pending the implementation of the corrective actions to address the non-monetary audit recommendations.

Health Net of California, Inc. – Southern Region

WOODLAND HILLS, CALIFORNIA

Report No. 1C-LP-00-16-022

FEBRUARY 24, 2017

Health Net of California, Inc. – Southern Region (Plan) has participated in the FEHBP since 1980, and provides health benefits to FEHBP members in Southern California. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-ups and MLR submissions. During this period, the FEHBP paid the Plan approximately $160.2 million in premiums.

Errors in the 2013 MLR Calculation Result in a $137,197 Penalty Underpayment to OPM

Our auditors questioned $137,197 for an MLR penalty underpayment in 2013. Although there are findings related to the 2012 MLR calculation, these findings resulted in no penalty due for this contract year. Specifically, we found that the Plan:

- Did not apply the allocation method proportionately and appropriately and included unallowable fees in determining the FEHBP tax expense; and,
- Overstated the medical and pharmacy claims used to derive the 2013 MLR by including improper payments as part of the total claims cost.

Health Net agreed with our findings related to the improper claim payments. They did not agree with our tax allocation adjustments. OPM closed two of our non-monetary recommendations in March 2017, and is in the process of resolving the remaining open items.

EXPERIENCE-RATED PLANS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan and health plans operated or sponsored by Federal employee organizations, associations, or unions. In addition, experience-rated HMOs fall into this category. The universe of experience-rated plans currently consists of approximately 100 audit sites. When auditing these plans, our auditors generally focus on three key areas:

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

During this reporting period, we issued five experience-rated final audit reports. Our experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, cash management activities, and/or fraud and abuse program activities. In these reports, our auditors recommended that the plans return $2.8 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross BlueShield Service Benefit Plan

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

The Association has established a Federal Employee Program (FEP) Director's Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract

with the Association, BCBS plans, and OPM. The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims, maintaining a history file of all FEHBP claims, and an overall accounting for all program funds.

We issued four BCBS experience-rated reports during the reporting period. Our auditors identified $25.4 million in questionable costs charged to the FEHBP contract. Summaries of these final reports are provided below and on pages 12 – 17 (as part of the Information Systems Audits) to highlight our notable audit findings.

Aging Refunds, Fraud Recoveries, and Medical Drug Rebates Sample of BlueCross and/or BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-16-010

JANUARY 31, 2017

BCBS Plans Returned All of the Questioned Amounts to the FEHBP

For a sample of 24 BCBS plans (from a universe of 64 BCBS plans), our audit covered aging FEP refunds that were held by these plans as of June 30, 2015, and fraud recoveries and medical drug rebates that were received by these plans from 2012 through June 30, 2015. Our sample included all BCBS plans with FEHBP health benefit payments of $350 million or less in 2014.

The objectives of our audit were to determine whether the 24 BCBS plans in our sample returned health benefit refunds, fraud recoveries, and medical drug rebates to the FEHBP in accordance with the terms of the contract and applicable regulations. Our auditors identified monetary findings for nine of the plans, questioning $202,316 for unreturned health benefit refunds, fraud recoveries, and medical drug rebates and $6,343 for lost investment income (LII). We also identified a procedural finding regarding corporate funds that were inadvertently held in the dedicated FEP investment account by a BCBS plan.

The applicable BCBS plans agreed with our monetary and procedural findings and returned the questioned amounts of $208,659 to the FEHBP.

BlueCross BlueShield of Massachusetts

BOSTON, MASSACHUSETTS

Report No. 1A-10-11-16-027

MARCH 27, 2017

Auditors Question $111,434 in Administrative Expense Overcharges and Lost Investment Income

Our audit of the FEHBP operations at BlueCross BlueShield of Massachusetts (Plan) covered miscellaneous health benefit payments and credits, administrative expense charges, and cash management activities from 2011 through 2015. We also reviewed the Plan's fraud and abuse program activities and practices from January 2015 through March 2016. For contract years 2011 through 2015, the Plan processed approximately $2.5 billion in FEHBP health benefit payments and charged the FEHBP $152.5 million in administrative expenses.

We questioned $111,434 in administrative expense overcharges and applicable LII; and our auditors identified a procedural finding regarding the Plan's fraud and abuse program.

For the procedural finding regarding the Plan's fraud and abuse program, we determined that the Plan and FEP Director's Office are not in full compliance with the communication and reporting requirements for fraud and abuse cases described in the FEHBP contract and Carrier Letter 2014-29. Specifically, the Plan and the FEP Director's Office did not report, or did not timely report, all fraud and abuse cases to OPM's OIG.

Without awareness of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

The Association and the Plan agreed with the questioned amounts and partially agreed with the procedural finding.

EMPLOYEE ORGANIZATION PLANS

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

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

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

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans fall into one of two categories: community-rated or experience-rated. As we previously explained on page 1 of this report, the key difference between the categories stems from how premium rates are calculated.

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

HMO Missouri, Inc.

MASON, OHIO

Report No. 1D-9G-00-16-008

MARCH 13, 2017

HMO Missouri, Inc. (Plan), is an experience-rated HMO offering health benefits to Federal enrollees and their families. Plan enrollment is open to all Federal employees and annuitants who live or work in the Plan's service area, which includes St. Louis, Missouri; Central and Southwest Missouri; and St. Clair and Madison counties in Illinois.

HMO Missouri, Inc. Returned the Questioned Amounts of $442,760 to the FEHB

Our audit of the Plan's FEHBP operations covered health benefit refunds and recoveries, and pharmacy and medical drug rebates from 2012 through June 2015. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from 2012 through June 2015, and the Plan's fraud and abuse program from January 2015 through September 2015. In addition, we expanded our audit scope to also include unallowable and/or unallocable cost centers that were potentially charged to the FEHBP from 2010 through 2015, as part of administrative expenses. For contract years 2012 through 2014, the Plan processed approximately $197 million in FEHBP health benefit payments and charged the FEHBP $7 million in administrative expenses.

We questioned $442,760 in health benefit refunds and recoveries, administrative expense overcharges, cash management activities, and LII; and our auditors identified a procedural finding regarding the Plan's fraud and abuse program. The monetary findings included the following:

- $360,340 for unreturned health benefit refunds and recoveries;
- $58,098 for letter of credit account overdraws (representing overcharges to the FEHBP) and $3,612 for applicable LII on these overdraws; and,
- $19,332 for administrative expense overcharges and $1,378 for applicable LII on these overcharges.

For the procedural finding regarding the Plan's fraud and abuse program, we determined that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases described in the FEHBP contract and Carrier Letter 2014-29. Specifically, the Plan did not report all fraud and abuse cases to OPM's OIG. Without notification of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

The Plan agreed with our monetary and procedural findings and returned all of the questioned amounts to the FEHBP.

Information Systems Audits

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

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

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

Audit of Global Coordination of Benefits for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-15-060

OCTOBER 13, 2016

We conducted a limited scope performance audit to determine whether the BCBS plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract with the OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to coordination of benefits (COB) with Medicare.

The audit covered health benefit payments from October 1, 2014 through June 30, 2015. We performed a computer search on our claims data warehouse to identify all BCBS claims paid during the scope of this audit that potentially were not coordinated with Medicare. From this universe we selected two separate samples of claims to review as part of the audit. The first was a review of all claims above a high dollar threshold, and the second was a statistical sample of lower dollar claims.

This report questioned $6.4 million in health benefit charges that were potentially not coordinated with Medicare.

For many years, we have had serious concerns with the BCBS plans' and the Association's efforts to implement corrective actions to prevent COB claim payment errors. Our audits (which have been performed annually since 2001) consistently demonstrate that retroactive claim adjustments and manual processing errors are the primary reasons for COB claim payment errors.

Auditors Question $6.4 Million in Health Benefit Charges Not Coordinated with Medicare

We do acknowledge that the Association has taken several steps to implement prior OIG audit recommendations to reduce COB errors. However, the results of this current audit indicate that these corrective actions have not had a substantial impact in reducing COB payment errors.

Plans are not contractually required to return improper payments made "in good faith" to the FEHBP trust fund if "diligent" efforts to recover them from the payee are unsuccessful. However, considering the many years that the Association has allowed these improper payments to occur without implementing the controls to prevent them, we do not believe that they were made in good faith. Therefore, we recommended that the entire questioned amount be returned to the FEHBP regardless of the plans' ability to recover the funds.

Web Application Security Review

WASHINGTON, D.C.

Report No. 4A-CI-00-16-061

OCTOBER 13, 2016

We volunteered to participate in a Government-wide project to examine the controls used to manage and secure the Federal Government's publicly accessible web applications. This project was led by the Council of Inspectors General on Integrity and Efficiency (CIGIE). The three main objectives of the review were to: 1) develop methodology for conducting reviews of Federal web applications that face the public Internet, 2) determine the effectiveness of agencies' efforts to identify and mitigate vulnerabilities on publicly accessible web applications, and 3) assess efforts to control or reduce the number of publicly accessible web applications and services.

Our review determined that there are multiple opportunities for improvement regarding the policies, procedures, and controls surrounding OPM's web applications that face the public Internet. OPM does not maintain an adequate inventory of web applications or have policies and procedures specific to web application development or security. In addition, OPM has not historically conducted web application vulnerability scans, and the scans conducted by the OIG during this engagement discovered multiple vulnerabilities in OPM's web applications and the servers hosting those applications.

As a result, we recommended that OPM create a formal web application inventory, create or enhance policies and procedures to address web application development and security, and implement a comprehensive web application vulnerability scanning program.

Federal Information Security Modernization Act Audit

WASHINGTON, D.C.

Report No. 4A-CI-00-16-039

NOVEMBER 9, 2016

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

We audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's (OMB) fiscal year (FY) 2016 Inspector General Federal Information Security Modernization Act Reporting Metrics. Our audit report again communicated a material weakness related to OPM's Security Assessment and Authorization (Authorization) program. In April 2015, the then Chief Information Officer issued a memorandum that granted an extension of the previous Authorizations for all systems whose Authorization had already expired, and for those scheduled to expire through September 2016, effectively imposing a moratorium on Authorization activity. Although this moratorium on Authorizations has since been lifted, the effects of the April 2015 memorandum continue to have a significant negative impact on OPM. At the end of FY 2016, the agency still had at least 18 major systems without a valid Authorization in place.

However, OPM initiated an "Authorization Sprint" during FY 2016 in an effort to bring the agency's

systems into compliance with the Authorization requirements. We acknowledge that OPM is once again taking system Authorization seriously. We are currently completing a comprehensive audit of OPM's Authorization process and have preliminary concerns about the effectiveness of the "Authorization Sprint."

Our audit report also re-issued a significant deficiency related to OPM's information security management structure. Although OPM has developed a security management structure that we believe can be effective, there has been an extremely high turnover rate of critical positions. The negative impact of these staffing issues is apparent in the results of our current FISMA audit work. There has been a significant regression in OPM's compliance with FISMA requirements, as the agency failed to meet requirements that it had successfully met in prior years. We acknowledge that OPM has placed significant effort toward filling these positions, but simply having the staff does not guarantee that the team can effectively manage information security and keep OPM compliant with FISMA requirements. We will continue to closely monitor activity in this area throughout FY 2017.

Material Weaknesses Still Exist in OPM's Authorization Program

In addition, we documented the following controls in place and opportunities for improvement:

- OPM has made improvements to its continuous monitoring program and is now rated as Level 2 ("Defined") based upon the CIGIE maturity model.
- OPM has also made improvements to its security incident program and is now rated as Level 2 ("Defined") based upon the CIGIE maturity model.
- OPM has developed an inventory of servers, databases, and network devices, but its overall inventory management program could be improved.
- OPM does not have configuration baselines for all operating platforms. This deficiency impacts the agency's ability to effectively audit and monitor systems for compliance.
- OPM has made progress in its vulnerability management program. However, improvements are needed in both the scanning and remediation processes.
- Multi-factor authentication is not required to access OPM systems in accordance with U.S. OMB memorandum M-11-11.

BlueCross BlueShield of North Carolina

DURHAM, NORTH CAROLINA

Report No. 1A-10-33-15-009

NOVEMBER 10, 2016

The objectives of our audit were to determine whether BCBS of North Carolina charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of its contract with OPM, which includes, by reference, the Federal Acquisition Regulation. Specifically, our objective was to determine whether BCBS of North Carolina complied with contract provisions relative to claim payments. The scope of our audit was contract years 2011 through 2014.

Our audit identified a major issue related to BCBS of North Carolina negotiating unreasonable pricing allowances with U.S. Department of Veterans Affairs (VA) providers. As a result, claims for these providers were paid at the billed rate. However, it is common practice in the health insurance industry to negotiate heavily discounted rates with providers. We challenged these costs under the Federal Acquisition Regulation's concept of "reasonableness" which measures conduct against that of a prudent business person.

BCBS of NC Overcharged the FEHBP $17.7 Million in Claim Payments Made to VA Providers

BCBS of North Carolina is an experience-rated carrier, which means that all claim expenses and the associated administrative costs are drawn from the FEHBP trust fund. Because shortfalls in their

contingency reserve account in the trust fund can be adjusted with future premium increases, BCBS plans assume minimal risk participating in the FEHBP. As a result, there is less incentive to control costs for the FEHBP as there might be for the plans' commercial lines of business. It seems unlikely that a health plan operating as a prudent business would unnecessarily agree to pay claims at an undiscounted rate for its private customers.

The report questioned $17.7 for unreasonable claims payments to VA providers.

Information System General and Application Controls at UnitedHealthcare

PLYMOUTH, MINNESOTA

Report No. 1C-JP-00-16-032

JANUARY 24, 2017

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

UHC's Security Controls are Compliant; However, Several Areas for Improvement Noted

UHC is a subsidiary of UnitedHealth Group which offers a wide range of insurance products and services. Another subsidiary of UnitedHealth Group, Optum, manages data center operations and information security for all UnitedHealth Group subsidiaries. The operations of Optum were considered within the scope of this audit.

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

Security Management

UHC has established an adequate security management program.

Access Controls

UHC has implemented controls to prevent unauthorized physical access to its facilities, as well as logical controls to protect sensitive information.

Network Security

UHC has implemented an incident response and network security program. UHC has also implemented preventive controls at the network perimeter and performs security event monitoring throughout its network. However, UHC does not perform credentialed vulnerability scans on all systems in its network environment.

Configuration Management

UHC has developed formal configuration management policies and baselines for its operating platforms. Furthermore, UHC has a documented change control process for the documented baseline configurations. However, the vulnerability scans that we performed as part of this audit detected isolated instances of servers that were not configured in full compliance with the established baselines.

Contingency Planning

UHC's business continuity and disaster recovery plans contain the elements suggested by relevant guidance and publications. UHC also routinely tests these plans.

Claims Adjudication

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

Information Systems General and Application Controls at BlueShield of California

EL DORADO HILLS, CALIFORNIA

Report No. 1A-10-67-16-040

JANUARY 24, 2017

Our IT audit focused on the claims processing applications used to adjudicate FEHBP claims for BlueShield of California (BSC) members, as well as the various processes and IT systems used to support these applications. This engagement was a follow-up audit where we performed test work related to network security and configuration management that BSC restricted us from completing during a prior audit (Report No. 1A-10-67-14-006, issued July 9, 2014).

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

Network Security

BSC has implemented an incident response and network security program. BSC has also implemented preventive controls at its network perimeter and performs security event monitoring throughout the network. However, BSC's information systems have not been subject to full-scope credentialed vulnerability scans.

Configuration Management

BSC has developed formal configuration management policies. However, we noted several areas of concern related to BSC's configuration management controls:

Improvements Still Needed for Network Security and Configuration Management

- BSC's IT environment contains systems that are running on unsupported operating platforms.
- BSC has not maintained, documented, and approved configuration standards for each operating platform used in its environment.
- BSC's configuration compliance auditing program could be improved by incorporating the documented configuration standards mentioned above and by using appropriate credentials when performing compliance scanning.

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. One critical area of this activity is the audit of OPM's consolidated financial statements required under the Chief Financial Officers Act (CFO) of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with Government Auditing Standards (GAS) issued by the Comptroller General of the United States. OPM contracted with the independent certified public accounting firm Grant Thornton LLP (Grant Thornton) to audit the consolidated financial statements as of September 30, 2016, and for the FY then ended. The contract requires that the audit be performed in accordance with generally accepted Government auditing standards (GAGAS) and the U.S. Office of Management and Budget (OMB) Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, as amended.

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

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

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

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

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

In addition to the consolidated financial statements, Grant Thornton performed the audit of the closing package financial statements as of September 30, 2016 and 2015. The contract requires that the audit be done in accordance with GAGAS and the OMB Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, as amended. The U.S. Department of the Treasury and the Government Accountability Office use the closing package in preparing and auditing the *Financial Report of the United States Government*.

OPM's FY 2016 Consolidated Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-16-030

NOVEMBER 10, 2016

Grant Thornton audited OPM's balance sheets as of September 30, 2016, and the related consolidated financial statements. Grant Thornton also audited the individual balance sheets of the Retirement, Health

Benefits and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2016, and the Programs' related individual financial statements for those years. The Programs, which are essential to the payment of benefits to Federal civilian employees, annuitants, and their respective dependents, operate under the following names:

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

Grant Thornton reported that OPM's consolidated financial statements and the Programs' individual financial statements as of and for the year ended September 30, 2016, were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. Grant Thornton's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

> *An **internal control deficiency** exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct misstatements on a timely basis.*
>
> *A **significant deficiency** is a deficiency, or combination of deficiencies, in an internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.*
>
> *A **material weakness** is a deficiency, or combination of deficiencies, in an internal control, such that there is a reasonable possibility that a material misstatement of the entity's financial statements will not be prevented, or detected and corrected on a timely basis.*

Grant Thornton identified one material weakness and one significant deficiency in monitoring internal controls. The areas identified by Grant Thornton are:

- ***Information Systems Control Environment:*** OPM is charged with the oversight and accountability for the governance of the information technology (IT) control environment, including general IT controls, and has not taken appropriate action to address ongoing pervasive deficiencies that have been identified in multiple information systems and reported to management as a significant deficiency or material weakness since FY 2007. This resulted in a material weakness.
- ***Monitoring Internal Controls:*** OPM postponed testing for 16 of 26 financially relevant areas, which were planned to be tested during FY 2016 to future fiscal years. Of the 16 postponed areas, 5 were considered by management to be 'High Risk' and, therefore, per OPM policy, required to be evaluated annually. In addition, Entity Level Controls, while planned to be evaluated in FY 2016 as required by A-123 Appendix A, were not evaluated. Lastly, documentation of management's understanding of the agency's internal control over financial reporting was limited to descriptions of controls tested. This resulted in a significant deficiency.

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

Material Weakness and Significant Deficiency Reported In FY 2016

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

OPM's FY 2016 Closing Package Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-16-031

NOVEMBER 15, 2016

The closing package financial statements are required to be audited in accordance with GAGAS and the provisions of OMB's Bulletin No. 15-02. OPM's Closing Package Financial Statements comprise the: Government-wide Treasury Account Symbol Adjusted Trial Balance System (GTAS) Reconciliation Report – Reclassified Balance Sheets, and the related GTAS Reconciliation Reports – Reclassified Statements of net cost and Reclassified Statements of Operations and Changes in Net Position, and the related notes to the financial statements as of September 30, 2016. The notes to the financial statements comprise the following:

- The GTAS Closing Package Lines Loaded Report,
- Financial Report (FR) Notes Report (except for the information in the FR Notes Report entitled "2015 - September", "Prior Year", "PY", "Previously Reported", "Line Item Changes", "Threshold", and the information as of and for the year then ended September 30, 2015 in the "Text Data" of the FR Notes Report), and
- The accompanying Additional Note No. 28.

Grant Thornton reported that OPM's closing package financial statements are presented fairly, in all material respects.

Grant Thornton noted no matters involving the internal control over the financial process for the closing package financial statements that are considered a material weakness or significant deficiency. In addition, Grant Thornton disclosed no instances of noncompliance or other matters that are required to be reported. The objectives of Grant Thornton's audits of the closing package financial statements did not include expressing an opinion on internal controls or compliance with laws and regulations, and Grant Thornton, accordingly, did not express such opinions.

FY 2016 Closing Package Statements Receive Another Clean Opinion

Special Audits

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

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

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

Federal Employees Dental and Vision Insurance Program Operations as Administered by United Concordia Dental for Contract Years 2011 through 2013

HARRISBURG, PENNSYLVANIA

Report No. 1J-OG-00-16-017

DECEMBER 21, 2016

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

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

United Concordia Overcharged FEDVIP by Approximately $23.3 Million

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

Our audit identified five deficiencies that require corrective action. Specifically, the Plan:

- Failed to submit certified Annual Accounting Statements (AAS) for its FEDVIP operations in 2011 and 2012;
- Overstated premiums received and expenses incurred by approximately $17.2 million in its 2011 through 2013 AAS for FEDVIP operations;
- Has never identified or reported a single fraud and abuse case to OPM under the fraud and abuse program, and the costs for its program far exceeded any recovery and savings for FEDVIP during the scope of our audit;
- Failed to meet several customer service performance standards that it guaranteed for 2011 through 2013; and,
- Overcharged the FEDVIP by approximately $23.3 million due to its use of an exaggerated completion factor to project claims for 2012 and 2013, and because the maximum administrative cost and profit loadings in the 2013 premium rate proposal were exceeded.

COMBINED FEDERAL CAMPAIGN

The Combined Federal Campaign (CFC) is the only authorized charitable fundraising drive conducted in Federal installations throughout the world. OPM has the responsibility, through both law and executive order, to regulate and oversee the conduct of fundraising activities in Federal civilian and military workplaces worldwide.

CFCs are identified by geographical areas that may include only a single city, or encompass several cities or counties. Our auditors review the administration of local campaigns to ensure compliance with Federal regulations and OPM guidelines. In addition, all campaigns are required by regulation to have an independent public accounting firm (IPA) audit their respective financial activities for each campaign year. The audit must be in the form of an agreed-upon procedures engagement to be completed by an IPA. We review the IPA's work as part of our audits.

CFC audits do not identify savings to the Government, because the funds involved are charitable donations made by Federal employees. Our audit efforts occasionally generate an internal referral to our criminal investigators for potential fraudulent activity. OPM's Office of the Combined Federal Campaign (OCFC) works with the campaign to resolve the findings after the final audit report is issued.

LOCAL CFC AUDITS

The local organizational structure consists of:

- ***Local Federal Coordinating Committee (LFCC)***

  The LFCC is a group of Federal officials designated by the Director of OPM to conduct the CFC in a particular community. It organizes the local CFC; determines the eligibility of local charities; selects and supervises the activities of the Principal Combined Fund Organization (PCFO); encourages Federal agencies to appoint employees to act as Loaned Executives who work directly on the local campaign; ensures that Federal employees are not coerced to participate in the local campaign; and resolves issues relating to a local charity's noncompliance with the CFC policies and procedures.

- ***Principal Combined Fund Organization (PCFO)***

  The PCFO is a federated group or combination of groups, or a charitable organization, selected by the LFCC to administer the local campaign under the direction and control of the LFCC and the Director of OPM. The primary goal of the PCFO is to administer an effective and efficient campaign in a fair and even-handed manner aimed at collecting the greatest amount of charitable contributions possible. Its responsibilities include collecting and distributing CFC funds, training volunteers, maintaining a detailed accounting of CFC administrative expenses incurred during the campaign, preparing pledge forms and charity lists, and submitting to and cooperating fully with audits of its operations. The PCFO is reimbursed for its administrative expenses from CFC funds.

- ***Federations***

  A Federation is a group of voluntary charitable human health and welfare organizations created to supply common fundraising, administrative, and management services to its constituent members.

- ***Independent Organizations***

  Independent Organizations are organizations that are not members of a federation for the purposes of the CFC.

During the reporting period, we issued one audit of a local CFC which is summarized below.

Combined Federal Campaign of the National Capital Area for Contract Years 2013 through 2015

BETHESDA, MARYLAND

Report No. 3A-CF-00-16-036

JANUARY 24, 2017

The objective of our limited scope audit was to determine if the PCFO complied with Title 5, Code of Federal Regulations, Part 950 (the Federal regulations governing CFC operations), in regards to campaign receipts, disbursements and expenses.

Auditors Question $170,266 in Campaign Receipts and Distributions

Our limited scope audit identified two areas of non-compliance with the Federal regulations governing CFC operations. Specifically, the PCFO:

- Applied $155,036 in campaign receipts to the wrong campaign period; and,
- Failed to reissue $15,230 in campaign distributions that were either returned or uncashed.

Enforcement Activities

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with over $1 trillion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over nine million current and retired Federal civilian employees, including eligible family members, and disburse over $135 billion annually. The majority of our OIG criminal investigative efforts are spent examining potential fraud against these trust funds. However, we also investigate OPM employee and contractor misconduct and other wrongdoing, such as fraud within the personnel security and suitability program conducted by OPM's National Background Investigations Bureau (NBIB).

During the reporting period, our office opened 171 investigations and closed 65, with 267 still in progress. Our investigations led to 47 arrests, 54 indictments and informations, 30 convictions and $4,578,116 in monetary recoveries to OPM-administered trust funds. Our investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in $55,363 in criminal fines and penalties, which are returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a statistical summary of our office's investigative activity, refer to the table on page 35.

HEALTH CARE FRAUD CASES

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal and civil investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to participate in the FEHBP. Of particular concern are cases that involve harm to the patients, pharmaceutical fraud, and the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

We remain very concerned about the FEHBP's exclusion from the Anti-Kickback Act and have proposed legislation to correct that omission. In our experience, the FEHBP is frequently victimized by the payment of kickbacks. Please see the message from the Acting Inspector General at the beginning of this report.

We coordinate our health care fraud investigations with the Department of Justice (DOJ) and other Federal, state, and local law enforcement agencies. We are participating members of health care fraud task forces across the nation. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.

Our special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and enrollees. Additionally, special agents work closely with our auditors when fraud issues arise during carrier audits. They also coordinate with the OIG's debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions. The following investigative cases represent some of our activity during the reporting period.

HEALTH CARE FRAUD CASES

Podiatrist Sentenced to 8 Years for $5 Million Health Care Fraud

From January 2008 to October 2014, a podiatrist, who operated *A Foot Above Podiatry* in Havertown, Pennsylvania submitted fraudulent bills to Medicare and the FEHBP for approximately $5 million for certain podiatric procedures that were not performed, and other procedures that were not medically necessary. In some cases, he provided "pill seeking" patients with prescriptions for oxycodone, a dangerous and addictive opioid medication, in exchange for payments from health insurance providers. Individuals seeking oxycodone received painful injections in their toes and feet, for which he submitted fraudulent claims to the patients' insurance providers. The podiatrist administered these medically unnecessary injections to create the appearance of legitimacy for his prescription of opioids.

In August 2016, the podiatrist pled guilty and was arraigned. In addition, as a condition of his plea, he surrendered his Drug Enforcement Administration (DEA) license and was excluded from practicing as a doctor of podiatric medicine.

In February 2017, he was sentenced to serve 97 months in Federal prison and to serve three years of supervised release from prison. Additionally, he was ordered to pay restitution of $4,960,296 to Medicare, Medicaid, and the FEHBP. The FEHBP will receive $1,215,273.

This case was investigated by the: DEA, U.S. Department of Health and Human Services (HHS) OIG, Federal Bureau of Investigation (FBI), Railroad Retirement Board (RRB) OIG, and our office.

Clinical Laboratory Held Liable for Civil Damages

This investigation was referred to the OPM OIG by the BCBS Association which advised that multiple local BCBS plans discovered they had paid claims for Antigen Leukocyte Cellular Antibody Test (ALCAT), despite policies in effect that ALCAT testing was not a covered service. Cell Science Systems (CSS), marketed the ALCAT to physician and chiropractic providers as a reimbursable service.

While CSS did not often directly bill insurance companies, the evidence showed that through its sales representatives, CSS told medical providers who purchased ALCAT tests how to submit claims for reimbursement. The instructions told doctors what Current Procedural Terminology (CPT) billing code to use and the number of units to bill in order to receive reimbursement for ALCAT testing. Evidence of these instructions included sales materials and presentations as well as doctor interviews. Moreover, based on insurance policies and newsletters, the OPM OIG contended that CSS knew, or should have known, many BCBS plans did not cover ALCAT testing.

The U.S. Attorney's Office, Northern District of Texas pursued a civil false claims actions against CSS and a settlement was obtained based on the findings of this investigation. Although CSS did not submit claims or receive direct reimbursement from the FEHBP, it was held civilly liable for damages.

OPM was awarded single damages in the amount of $197,412, investigative costs of $132,331, and lost investment income of $24,653, for a total recovery of $354,396. This case was investigated solely by the OPM OIG.

Florida Hospital Agrees to Pay $12.5 Million Settlement for Allegations of Violating the False Claims Act

In December 2016, South Miami Hospital, a not-for-profit regional hospital located in South Miami, Florida agreed to pay the United States $12.5 million to settle allegations that it violated the False Claims Act by submitting false claims to Federal healthcare programs for medically unnecessary electrophysiology studies and other procedures.

The allegations arose from a lawsuit filed by two whistleblowers under the *qui tam* provisions of the False Claims Act. It was alleged that South Miami Hospital engaged in a number of unnecessary cardiac procedures, including echocardiograms, electrophysiology studies, head upright tilt tests, and other treatments of arrhythmia by ablation, cryoablation, or implantation of an electronic device, for the sole purpose of increasing the amount of physician and hospital reimbursements paid by Medicare and other Federally-funded programs.

*A **qui tam** lawsuit may be filed on behalf of the Federal government if an individual has knowledge of a person or company filing false claims. The government may intercede or allow the plaintiff or relator to prosecute the lawsuit on its behalf. If the qui tam lawsuit is successful the relator receives a reward of 15-25 percent of the recovery if the government interceded; or 25-30 percent if the government did not intercede.*

The settlement was the result of a coordinated effort by the HHS OIG, Defense Criminal Investigative Service (DCIS), and our office. As a result of the settlement, the FEHBP will receive $34,363.

Otolaryngologist Enters Civil Settlement to Resolve Disputed Claims

In February 2017, a Plantation, Florida otolaryngologist entered into a civil settlement agreement with the Federal Government agreeing to pay a total of $750,000 to resolve disputed claims related to billing for surgeries that allegedly were not necessary or were not provided.

The investigation determined that the otolaryngologist routinely performed diagnostic endoscopies on patients but billed these diagnostic procedures as more expensive and intrusive surgical debridement. Surgical debridement is a specialized procedure frequently performed following sinus surgery involving the transnasal insertion of an endoscope and parallel insertion of various instruments to remove post-surgical crusting, bone or tissue deposits. It may also be used to remove crusts and debris in patients with longstanding chronic sinusitis who have undergone surgery in the past.

The FEHBP will receive $25,259 as a result of the settlement. This case was worked jointly with the FBI, HHS OIG, and OPM OIG.

Health Care Provider Agrees to Pay $60 Million to Settle False Claims Act Allegations

This investigation was predicated on a *qui tam* filed against IPC The Hospitalist Company, Inc. (IPC) in the U.S. District Court for the Northern District of Illinois, alleging that IPC and its affiliates and subsidiaries knowingly and systematically billed for higher and more expensive levels of medical service than were actually performed, a practice commonly referred to as "upcoding". In September 2016, the OPM OIG opened an investigation into IPC.

The investigation found that beginning January 2003, IPC and its affiliates and subsidiaries knowingly and systematically billed Medicare and Medicaid, and other Federal payers including TRICARE, FEHBP, and the RRB, for higher and more expensive levels of medical service than were actually performed.

In February 2017, a settlement agreement was obtained with Team Health Holdings, Inc. ("TeamHealth"), as successor-in-interest to IPC Healthcare, Inc. The terms of that settlement established that TeamHealth also shall pay the United States $56,625,000, in addition to interest. TeamHealth shall pay to the State Medicaid programs pursuant to separate agreements with participating states the sum of up to $3,375,000. The FEHBP received $470,450 in restitution.

The case was investigated jointly with the HHS OIG, DCIS, and RRB OIG.

Former DOD Employee Guilty of Health Care Fraud

Our office conducted an investigation of a former DOD civilian employee who submitted false claims to the FEHBP for services he did not receive. The former DOD employee, stationed in Germany, submitted 66 invoices representing over 1,300 health claims totaling over $150,000 for visits with a German physical therapist for treatment to his back and his legs that never occurred. Our investigation determined that the employee used DOD fax and computer equipment to submit these fraudulent claims to the Foreign Service Benefit Plan in Washington, District of Columbia. We worked with the health plan, DCIS, and the U.S. Department of Veterans Affairs (VA) and were able to prove that these claims were fictitious.

In November 2016, the former employee entered a guilty plea to one-count of health care fraud. In February 2017, he was sentenced to 60 months of probation, 180 days of home detention, and ordered to pay restitution in the amount of $143,111.

This was a joint investigation between the DCIS and OPM OIG.

Virginia Cardiology Center Settles with Government Health Programs

A Virginia cardiology center was allegedly engaging in improper patient referrals, in addition to allegations that the physicians may have billed for services they did not or could not have provided. During the course of this joint investigation, we did not uncover any evidence that the doctors knowingly or intentionally misrepresented the services they provided. However, the Government contended that an overpayment occurred because the cardiology group misrepresented the physical location of certain procedures that they provided. The place of service (POS) indicated on a claim may affect reimbursement rates.

In October and December 2016, the cardiology group settled all alleged violations with the U.S. Attorney's Office in the Eastern District of Virginia through four distinct settlement agreements amongst the practice doctors. Through this agreement, the FEHBP recovered $62,137.

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

Anesthesia Practice Self-Discloses Overbilling

In 2010, a Virginia anesthesia group partnered with a billing company to ensure efficient and accurate billing for their practice. During a routine review, the group discovered that between January 2011 and May 2012 they had been overpaid by an FEHBP carrier for the billing of anesthesia units.

> ***Anesthesiologists*** *are paid for their services pursuant to a formula of base units added to time units which are calculated in fifteen minute increments based on the amount of time that anesthesia was provided to patients.*

Upon identifying the discrepancy, the anesthesia group contacted the FEHBP carrier and attempted to resolve the issue. Our office became involved and

found that there was no intent to defraud the FEHBP, but rather the third-party biller mistakenly included both base and time units, instead of just time units, thus leading to double billing.

We were able to settle the overpaid claims through civil negotiations with the U.S. Attorney's Office in the Eastern District of Virginia. In February 2017, we recovered $336,138 for the erroneously paid claims along with an additional $33,579 in coinsurance payments made in error by FEHBP members.

Dermatology Practice Settles Allegations of Pass-Through Billing and the Use of Non-Licensed Medical Support Staff

A Virginia dermatologist settled allegations of pass-through billing and the use of non-licensed or non-certified medical support staff for dermatologic procedures including Mohs surgeries.

> ***Pass-through billing*** *occurs when the ordering provider requests and bills for a service, but the service is not performed by the ordering provider.*

The Government alleged that a billing physician or other supplier must identify the performing supplier and indicate the performing supplier's net charge for services and if the billing physician or other supplier fails to provide this information, the Government may not make payment for those services. The Government also alleged that Federal health programs will not reimburse for services that are performed by an individual who is not licensed or certified under applicable state laws to perform those services. Regardless of whether this person was supervised by a licensed individual, major surgical procedures cannot be billed if performed by unlicensed health care personnel, such as medical assistants.

In March 2017, the dermatologist entered into a global resolution settlement with Government payers in which the FEHBP recovered $62,766.

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

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). The most common type of retirement fraud involves the intentional receipt and use of Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS) annuity benefit payments by an unentitled recipient. However, retirement fraud can also include incidents of elder abuse.

Our Office of Investigations uses a variety of approaches to identify potential retirement fraud cases for investigation. We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. We also coordinate with the U.S. Department of the Treasury's Financial Management Service to obtain payment information. Other referrals come from Federal, state, and local agencies, as well as private citizens. The OIG also works proactively to identify retirement fraud.

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

RETIREMENT FRAUD CASES

Daughter Steals Annuity Benefits

We received a fraud referral from OPM's Retirement Inspections Branch to investigate the overpayment of an annuitant's retirement and survivor annuity payments that continued after death. The annuitant's August 2012, death was not reported to OPM and benefit payments continued through August 2014, resulting in an overpayment of $83,865 for the retirement annuity and $103,282 on the survivor annuity. Our investigation discovered that the annuitant's daughter maintained a joint account with the annuitant where the annuity benefit payments were electronically deposited. Special agents interviewed the daughter who admitted that she converted the annuity payments to her own personal use after her mother's death. The daughter confessed

that she received correspondence from OPM inquiring as to the vital status of her mother but she ignored this correspondence knowing that the benefits would be discontinued if she informed OPM of her mother's death. After the Department of the Treasury's reclamation process, the net balance due for the entire overpayment was $138,047.

A Special Assistant U.S. Attorney in the Eastern District of Virginia initiated a civil action to recover the overpayment. In January 2017, the defendant settled this matter with the Government, agreeing to repay $112,714 via one lump sum payment of $100,000 and 36 subsequent payments in monthly installments to settle her debt.

Son Steals Mother's Annuity Payments

We initiated this investigation after receiving an allegation that a Federal survivor annuitant died in 2007 and her son continued to receive her survivor annuity benefit payments for over six years.

Our investigation confirmed that the annuitant's son maintained a joint bank account with the annuitant where the annuity benefit payments were electronically deposited. The annuitant died in April 2007, and OPM was not notified of her death. OPM continued to issue annuity payments via electronic funds transfer to the bank account jointly held by the annuitant and her son, resulting in an overpayment of $60,874.

In August 2015, the annuitant's son was indicted for theft of public money in the Western District of North Carolina. In September 2015, he was arrested. In November 2016, the U.S. Attorney's Office moved to dismiss the indictment against the annuitant's son after he agreed to the terms of the Pre-Trial Diversion Agreement. As part of the agreement, the son will make restitution of $60,874 to OPM.

Son Administratively Settles Overpayment Debt but Fails to Follow Through

In April 2013, OPM OIG's investigative support group identified the death of a Federal Civil Service Retirement System annuitant through a proactive project. Through our investigation, we determined that the annuitant died in October 2009, and benefits were electronically deposited into the annuitants account after death resulting in an improper payment of $63,769 from October 2009 through March 2013. The net overpayment amount after the Department of the Treasury's reclamation process left a balance due of $52,047. We interviewed the son of the deceased annuitant through his attorney and pursued this overpayment. In March 2016, the son agreed to repay the debt, but failed to follow though in a timely fashion, leading OPM to initiate recovery in March 2017, through the Department of the Treasury in accordance with the Debt Collection Improvement Act for the outstanding balance of $52,137, including interest.

REVOLVING FUND PROGRAM INVESTIGATIONS

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

Prior to the establishment of the National Background Investigations Bureau (NBIB) effective October 1, 2016, OPM's Federal Investigative Services (FIS) conducted background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducted 95 percent of all personnel background investigations for the Federal Government. With a staff of over 8,800 Federal and contract employees, FIS processed over 2.6 million background investigations in FY 2016. Federal agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

The violations investigated by our criminal investigators include contract violations, as well as fabrications by OPM background investigators (i.e., the submission of work products that purport to represent investigative work which was not in fact performed). We will continue to provide this necessary investigative oversight for the NBIB. We consider such cases to be a serious national security and public trust concern. If a background investigation contains incorrect, incomplete, or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities or classified information.

OPM's Human Resources Solutions (HRS) provides other Federal agencies, on a reimbursable basis, with human resource products and services to help agencies develop leaders, attract and build a high quality workforce, and transform into high performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following Revolving Fund investigations represents some of our activities during the reporting period.

Former OPM Contract Background Investigator Convicted of Falsifying Numerous Background Investigations

In September 2012, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by a former OPM contract background investigator employed by USIS.

From August 2011 to September 2012, in more than thirty Reports of Investigations, the background investigator indicated that he had interviewed a source or reviewed a record regarding the subject of the background investigation, when in fact, he had not conducted the interview or obtained the records of interest. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

The former USIS contract background investigator pled guilty to making a false statement, in the U.S. District Court for the District of Columbia. He was sentenced in November 2016 to serve 60 days incarceration, 6 months of home detention, 36 months of supervised probation, conduct 100 hours of community service, and ordered to pay restitution of $264,312 to OPM.

INTERNAL AND ADMINISTRATIVE INVESTIGATIONS

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

Senior OPM Official Violates Ethics Standards

Our office conducted an investigation of a GS-15 OPM employee and concluded that he violated the Standards of Ethical Conduct for Employees of the Executive Branch by engaging in outside activities that were a conflict of interest. The employee owned his own company, and in 2013 he conducted private, for-profit seminars for small business owners seeking to obtain Federal Government contracts, when providing similar services was part of his Federal job. Further, the employee used his official OPM title when advertising the seminars. Our investigation also found that the employee recorded a YouTube video, inside

his office at OPM and using his OPM title, to promote a conference sponsored by a private company at which he had been invited to speak in a personal capacity. Finally, we concluded that the employee managed an OPM office that made two micro-purchases from a firm in late 2012, during the same time period that the employee retained the same firm in a personal capacity to provide consulting services related to his outside business interests. This case was presented to the U.S. Department of Justice, Public Integrity Section, which declined prosecution on or about September 13, 2016. During this reporting period, the matter was referred to OPM for action deemed appropriate.

Former OPM Contract Systems Administrator Convicted of Falsifying Multiple Time & Attendance Reports

In April 2012, a contract employee was hired to work at OPM as a contract Systems Administrator for OPM's Planning and Policy Analysis (PPA), Program Management Office, and the OPM OIG, in Washington, DC. The contract employee was specifically hired to implement system enhancements on the joint OIG and PPA Data Warehouse project, not to conduct research as later claimed by the employee. The vast majority of the contract employee's job functions were hands-on systems administration and implementation activities, and the OIG would not have paid nor hired the contract employee to solely conduct research.

In late July 2012, the contract employee's fraudulent scheme was discovered by OIG and PPA management after they met to discuss cost settlements prior to the end FY 2012, since the costs were split between the OIG and PPA.

Our investigation uncovered that from May through August 2012, the contract employee worked at both OPM and the National Security Agency (NSA), but neither agency was aware of the other. The contract employee billed the OPM OIG for 323.75 hours for the time period ranging from May through August 2012, when he was not present at the work site. He was paid $43,706 for these hours. NSA OIG investigators later reviewed building records and uncovered a discrepancy of 269.5 hours in which the contract employee had submitted timesheets for hours he did not work on-site and was paid $26,940.

The former contract employee pled guilty to making a false statement and was sentenced in the U.S. District Court for the District of Columbia, to 3 months of home detention, 60 months of court supervised probation; ordered to complete 360 hours of community service over the next 5 years; and ordered to pay a total of $70,646 in restitution.

OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number and mailing address are listed on our OIG Web site at https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse, along with an online anonymous complaint form. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans. Those who report information to our Hotline can do so openly, anonymously, and confidentially without fear of reprisal.

The information we receive on our OIG Hotline generally concerns customer service issues, FEHBP health care fraud, retirement fraud, and other complaints that may warrant investigation. Our office receives inquiries from the general public, OPM employees, contractors and others interested in reporting waste, fraud, and abuse within OPM and the programs it administers.

We received 1,009 hotline inquires during the reporting period, with 191 pertaining to health care and insurance issues, 356 concerning retirement, 32 related to Revolving Fund programs, and the remainder fell into other categories. The table on page 43 reports the summary of hotline activities including telephone calls, emails, and letters.

OIG and External Initiated Complaints

Based on our knowledge of OPM program vulnerabilities, information shared by OPM program offices and contractors, and our liaison with other law enforcement agencies, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we opened 181 complaints. Of those complaints, 122 related to health care fraud, 44 involved retirement fraud, 9 pertained to OPM's Revolving Fund programs, and the remainder fell into other categories. These efforts may potentially evolve into formal investigations.

We believe that these OIG and external initiated complaints complement our hotline to ensure that our office continues to be effective in its role to guard against and identify instances of fraud, waste, and abuse.

Debarment Initiative Update

Effective March 2013, OPM implemented a suspension and debarment program, which is separate from the OIG's administrative sanctions of FEHBP health care providers. The program covers the debarment of OPM contractors and employees who have violated the terms of their contract or employment. During this reporting period, the OIG referred 6 cases to the agency for debarment action, for a total of 107 referrals since the inception of the program. OPM issued debarment letters to 3 individuals between October 1, 2016 and March 31, 2017. The OIG also referred 10 cases to the agency for suspension action. OPM issued suspension letters to 2 individuals during this reporting period.

The majority of cases we have referred for debarment action were former FIS employees and contractors. Most of these former FIS employees and contractors are referred to us through FIS's Integrity Assurance Group. Although these individuals were removed from Government employment or from the relevant OPM contract, we feel that Government-wide contract debarment action for these individuals is necessary to protect the integrity of Federal programs.

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

During this reporting period, the Office of Investigations also referred 22 cases involving health care providers to the OIG's Administrative Sanctions Group for potential suspension or debarment from the FEHBP.

Correction of Prior Semiannual Reports

In Appendix XI of our semiannual report for the period ending September 30, 2014, we underreported the total recovery amount by $615,000 and the OPM recovery amount by $92,379. In Appendix X of our semiannual report for the period ending March 31, 2015, we underreported the total recovery amount by $66,201 and the OPM recovery amount by $66,201. In Appendix X of our semiannual report for the period ending March 31, 2016, we underreported the total recovery amount by $6,916,795 and the OPM recovery amount by $43,472. This underreporting occurred because the recovery amounts for some cases were not available until after the prior semiannual reports were issued.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 34,613 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 383 administrative sanctions – including both suspensions and debarments – of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 2,228 sanctions-related inquiries.

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

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

Sanctions serve a protective function for the FEHBP and the Federal employees who obtain, through it, their health insurance coverage. The following cases, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk, or have obtained fraudulent payment of FEHBP funds.

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

***Suspension** has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.*

California Physician Suspended for Fraudulent Prescription Activities

In February 2017, we suspended a California physician based on a plea agreement filed with the U.S. District Court, Southern District of California. In March 2016, the physician entered into a plea agreement in which she pled guilty to one count of fraudulently acquiring a controlled substance.

A Federal investigation was initiated by our Office of Investigations, based on a complaint from a CVS Caremark investigator. The CVS investigator received a suspected fraud alert from the Federal Employee Program Customer Service Unit regarding an FEHBP enrollee reporting that he learned of a prescription that was filled in his name; however, he had not received a prescription for himself for approximately six years.

The results of the investigation revealed that the physician fraudulently obtained 22 prescriptions for a Schedule II controlled substance over a one-year period. Specifically, the physician called in and

obtained the prescriptions from CVS for hydrocodone, on behalf of the FEHBP enrollee who was not her patient nor had granted permission to obtain the prescriptions on his behalf. The prescriptions were subsequently billed to the enrollee's FEHBP insurance account.

In accordance with the plea agreement, the court granted a deferred sentencing for a 24-month period pending the completion of the agreement's terms and conditions. The conditions of the agreement stated that the physician must: remain under the supervision of the U.S. Pretrial Services; not violate and Federal, state, or local laws; and, pay $1,449 in restitution.

Federal regulations state that OPM may suspend providers of health care services from participating in the FEHBP pending the completion of an investigation or ensuing criminal, civil, or administrative proceeding. Therefore, our suspension will remain in effect pending successful completion of the plea agreement.

Michigan Physician and Practices Debarred After Suspension of Medical License

In October 2016, our office debarred a Michigan physician based on the Michigan Department of Licensing and Regulatory Affairs Board of Medicine's (Board) decision to suspend the physician's medical license. In 2015, the Board issued a suspension order after the U.S. District Court for the Eastern District of Michigan indicted him in June 2015 for health care fraud and conspiracy to pay or receive health care kickbacks.

The physician was a neurologist, and the owner of three health care facilities in the state of Michigan. He was indicted as part of a criminal conspiracy that included 242 doctors, nurses, patient recruiters, home health care providers, pharmacy owners, and other licensed medical professionals that participated in Medicare fraud schemes involving approximately $712 million in false billings. Patients were billed for equipment that was not provided; and for care and services that were not rendered. The charges followed an investigation conducted by the Attorney General's Medicare Fraud Strike Force.

The physician falsified treatment records by regularly noting in medical reports that he reviewed electromyography and nerve conduction studies tests. In addition, the physician prescribed controlled substances to Medicare beneficiaries as an inducement to provide their Medicare information for billing. He failed to run queries on his patients through the Michigan Automated Prescription System to determine if they were receiving controlled substances from other physicians.

Federal regulations state that OPM may debar providers of health care services from participating in the FEHBP whose license to provide a health care service has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance or financial integrity.

Our debarment of the physician is for an indefinite period pending full reinstatement of the physician's medical license. In addition, based on ownership and control, we debarred physician's three medical facilities, which were used in committing the fraudulent activities. This case was referred to us by our investigators.

Maryland Social Worker Debarred After Health Care Fraud Conviction

In November 2016, we debarred a Maryland social worker based on her September 2013 conviction of health care fraud by the U.S. District Court for the District of Maryland. She was sentenced to 18-months' probation, and ordered to pay $151,404 in restitution after she pled guilty.

The conviction followed several disciplinary actions taken against the practitioner by the Maryland State Board of Social Work Examiners (Board) that started in June 2005, when the Board suspended her license

for violating certain provisions of the Maryland Social Workers Act after conducting an investigation into complaints against her. The Board's investigation found her guilty of the following:

- Practiced clinical social work without a license;
- Misrepresented her credentials by using Licensed Certified Social Worker-Clinical (LCSW-C) on her patient notes;
- Failed to seek supervision when practicing psychotherapy;
- Disclosed personal information about herself to a patient;
- Breached patient confidentiality; and,
- Received gifts and failed to document financial transactions with patients.

In 2008, BCBS terminated the social worker as a participating provider; however, she continued as a non-participating provider. This allowed her to collect fees from patients who would submit claims to BCBS for reimbursement. In 2010, after discovering the status of her license, BCBS stopped all claims submitted by her patients.

In March 2013, she pled guilty to fraud, admitting that she continued to see patients insured by BCBS of Maryland after her license to practice social work was revoked. She submitted between $120,000 and $200,000, in fraudulent claims between 2005 and 2010.

Under the FEHBP's administrative sanctions statutory authority, convictions constitute a mandatory basis for debarment. We imposed a three-year term of debarment. This case was referred to us by our investigators.

Evaluations and Inspections Activities

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

We did not issue any evaluations and inspections reports during this period.

Statistical Summary of Enforcement Activities

Judicial Actions and Recoveries:

Indictments and Informations	54
Arrests	47
Convictions	30
Restitutions and Settlements	$4,578,116
Fines, Penalties, Assessments, and Forfeitures	$55,363[1]

OIG Executive Actions:

Investigative Reports Issued	53
■ Report of Investigation	52
■ Communication of Investigative Findings	1
Whistleblower Retaliation Allegations Confirmed	0
Subjects Presented for Prosecution	12
■ Federal Venue	10
■ State Venue	0
■ Local Venue	2

Administrative Sanctions Activity:

NBIB Cases Referred for Debarment and Suspension	16
NBIB Debarments and Suspensions	5
Health Care Debarments and Suspensions Issued	383
Health Care Provider Debarment and Suspension Inquiries	2,228
Health Care Debarments and Suspensions in Effect at End of Reporting Period	34,613

[1]*This figure represents criminal fines and criminal penalties returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures and court assessments and/or fees resulting from criminal investigations conducted by our office. Many of these criminal investigations were conducted jointly with other Federal agencies, who share the credit for the fines, penalties, assessments, and forfeitures.*

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Hotline Complaints and Complaints Received from Other Sources

	Health Care	Retirement	Revolving Fund	Other	Total
Hotlines Opened	191	356	32	430	1,009
Referred To:					
■ OPM Program Offices	67	222	18	40	347
■ FEHBP Insurance Carriers or Providers	37	N/A	N/A	N/A	37
■ Other Federal Or State Agencies	7	3	3	221	234
Informational Only	27	57	4	121	209
Complaint Opened	2	0	0	2	4
Issue Resolved	17	34	3	16	70
Hotlines Closed	157	316	28	400	901
Hotlines Open at End of Reporting Period	34	40	4	30	108
Complaints Received From Other Sources	122	44	9	6	181
Complaints Closed	356	69	34	16	475

Investigative Leads

	Total
Investigative Leads Received	1,102
Declined Due To:	
■ Low FEHBP Exposure	241
■ Lack of OIG Resources	209
■ Does Not Meet Reporting Guidelines	177
■ Allegations Not Substantiated by Carrier	7
Not Healthcare Related	6
Informational Only	190
Issue Resolved-No Referral	13
Referred to Other Agency	3
Complaints Initiated	36
Investigative Leads Closed	882
Investigative Leads Open at the End of Reporting Period	220

Note: The investigative statistics were determined and independently validated by running queries from our investigative tracking system to extract the investigative actions taken during the reporting period.

Appendices

APPENDIX I-A
Final Reports Issued With Questioned Costs for Insurance Programs
OCTOBER 1, 2016 TO MARCH 31, 2017

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	$ 4,909,692
B. Reports issued during the reporting period with findings	9	42,469,336
Subtotals (A+B)	13	47,379,028
C. Reports for which a management decision was made during the reporting period:	8	7,350,241
1. Disallowed costs	N/A	6,818,931
2. Costs not disallowed	N/A	531,3102[2]
D. Reports for which no management decision has been made by the end of the reporting period	5	40,028,787
E. Reports for which no management decision has been made within 6 months of issuance	2	887,942

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

APPENDIX I-B
Final Reports Issued With Questioned Costs for All Other Audit Entities
OCTOBER 1, 2016 TO MARCH 31, 2017

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	$163,937
B. Reports issued during the reporting period with findings	1	170,266
Subtotals (A+B)	5	334,203
C. Reports for which a management decision was made during the reporting period:	2	150,338
1. Disallowed costs	N/A	150,338
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	3	183,865
E. Reports for which no management decision has been made within 6 months of issuance	2	13,599

APPENDIX II
Final Reports Issued With Recommendations for Better Use of Funds
OCTOBER 1, 2016 TO MARCH 31, 2017

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	1	23,300,000
Subtotals (A+B)	2	132,180,417
C. Reports for which a management decision was made during the reporting period:	1	23,300,000
D. Reports for which no management decision has been made by the end of the reporting period	1	108,880,417
E. Reports for which no management decision has been made within 6 months of issuance	1	108,880,417

APPENDIX III

Insurance Audit Reports Issued

OCTOBER 1, 2016 TO MARCH 31, 2017

Report Number	Subject	Date Issued	Questioned Costs
lA-99-00-15-060	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.	October 13, 2016	$ 6,401,840
1M-0E-00-16-028	Multi-State Plan Program Operations at CareFirst BlueCross BlueShield of the District of Columbia in Baltimore, Maryland	October 13, 2016	0
lA-10-33-15-009	BlueCross and BlueShield of North Carolina in Durham, North Carolina	November 10, 2016	18,648,497
lC-MW-00-16-018	Humana CoverageFirst - Chicago in Louisville, Kentucky	November 21, 2016	0
lJ-OG-00-16-017	Federal Employees Dental and Vision Insurance Program Operations as Administered by United Concordia Dental for contract years 2011 through 2013 in Harrisburg, Pennsylvania	December 21, 2016	0
lC-JN-00-16-019	Aetna Open Access - Capitol Region in Blue Bell, Pennsylvania	January 31, 2017	16,169,511
lA-99-00-16-010	Aging Refunds, Fraud Recoveries, and Medical Drug Rebates for a Sample of 24 BlueCross and/or BlueShield Plans in Washington, D.C.	January 31, 2017	208,659
lC-DH-00-16-025	QualChoice in Little Rock, Arkansas	February 22, 2017	301,910
1C-MH-00-16-052	Humana Health Plan, Inc. - Louisville, Kentucky in Louisville, Kentucky	February 22, 2017	0
1C-LP-00-16-022	Health Net of California, Inc. - Southern Region in Woodland Hills, California	February 24, 2017	137,197
lC-LB-00-16-015	Health Net of California, Inc. - Northern Region in Woodland Hills, California	February 27, 2017	47,528
1D-9G-00-16-008	HMO Missouri, Inc. in Mason, Ohio	March 13, 2017	442,760
lA-10-11-16-027	BlueCross BlueShield of Massachusetts in Boston, Massachusetts	March 27, 2017	111,434
TOTALS			**$42,469,336**

APPENDIX IV
Internal Audit Reports Issued
OCTOBER 1, 2016 TO MARCH 31, 2017

Report Number	Subject	Date Issued
4A-CF-00-16-030	OPM's FY 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016
4A-CF-00-16-031	OPM's FY 2016 Closing Package Financial Statements in Washington, D.C.	November 16, 2016

APPENDIX V
Combined Federal Campaign Audit Reports Issued
OCTOBER 1, 2016 TO MARCH 31, 2017

Report Number	Subject	Date Issued	Questioned Costs
3A-CF-00-16-036	The Combined Federal Campaign of the National Capital Area for the 2013 through 2015 Campaign Periods in Bethesda, Maryland	January 24, 2017	$170,266

APPENDIX VI
Information Systems Audit Reports Issued
OCTOBER 1, 2016 TO MARCH 31, 2017

Report Number	Subject	Date Issued
4A-CI-00-16-039	Federal Information Security Modernization Act of FY 2016 in Washington, D.C.	November 9, 2016
IA-10-13-16-020	Information Systems General and Application Controls at Highmark BlueCross and BlueShield in Camp Hill and Pittsburgh, Pennsylvania	November 10, 2016
4A-RS-00-16-035	Information Technology Security Controls of OPM's Federal Annuity Claims Expert System in Washington, D.C.	November 21, 2016
1C-JP-00-16-032	Information Systems General and Application Controls at UnitedHealthcare in Plymouth, Minnesota	January 24, 2017
IA-10-67-16-040	Information Systems General and Application Controls at BlueShield of California in El Dorado Hills, California	January 24, 2017
IA-10-58-16-047	Information Systems General and Application Controls at Regence BlueCross BlueShield of Oregon in Portland, Oregon	March 27, 2017

APPENDIX VII
Special Review Reports Issued
OCTOBER 1, 2016 TO MARCH 31, 2017

Report Number	Subject	Date Issued
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016
4A-HI-00-17-013	Management Alert - Status of the Multi-State Plan Program in Washington, D.C.	December 8, 2016
4A-CF-00-16-038	Management Advisory Report – Digital Accountability and Transparency Act Readiness Review in Washington, D.C.	February 16, 2017

APPENDIX VIII
Summary of Reports More Than Six Months Old Pending Corrective Action
AS OF MARCH 31, 2017

Report Number	Subject	Date Issued
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008 in Washington, D.C.; 19 total recommendations; 2 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements in Washington, D.C.; 6 total recommendations; 1 open recommendation	November 14, 2008
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 2 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 1 open recommendation	November 13, 2009
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 3 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 2 open recommendations	November 10, 2010
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 3 open recommendations	September 14, 2011
4A-CI-00-11-009	Federal Information Security Management Act for FY 2011 in Washington, D.C.; 29 total recommendations; 3 open recommendations	November 9, 2011
4A-CF-00-11-050	OPM's FY 2011 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 1 open recommendation	November 14, 2011
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report and Receivables Tracking System in Washington, D.C.; 24 total recommendations; 5 open recommendations	July 16, 2012
4A-CI-00-12-016	Federal Information Security Management Act for FY 2012 in Washington, D.C.; 18 total recommendations; 4 open recommendations	November 5, 2012
4A-CF-00-12-039	OPM's FY 2012 Consolidated Financial Statements in Washington, D.C.; 3 total recommendations; 1 open recommendation	November 15, 2012
1K-RS-00-12-031	OPM's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.; 2 total recommendations; 1 open recommendation	December 12, 2012
1H-01-00-12-072	BlueCross and BlueShield's Retail Pharmacy Member Eligibility in 2006, 2007, and 2011 in Washington, D.C.; 11 total recommendations; 10 open recommendations	November 8, 2013

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Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2017

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-13-021	Federal Information Security Management Act for FY 2013 in Washington, D.C.; 16 total recommendations; 5 open recommendations	November 21, 2013
4A-CF-00-13-034	OPM's FY 2013 Consolidated Financial Statements in Washington, D.C.; 1 total recommendation; 1 open recommendation	December 13, 2013
4A-CF-00-14-009	OPM's FY 2013 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 1 total recommendation; 1 open recommendation	April 10, 2014
4A-CI-00-14-015	Information Technology Security Controls of the OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 5 open recommendations	June 6, 2014
4A-CI-00-14-028	Status of Cloud Computing Environments within the OPM in Washington, D.C.; 3 total recommendations; 2 open recommendations	July 9, 2014
Not Applicable	Review of FIS Background Investigation Process in Washington, D.C.; 3 total recommendations; 3 open recommendations	August 15, 2014
4A-RI-00-14-036	Information Technology Security Controls of OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems FY 2014 in Washington, D.C.; 10 total recommendations; 2 open recommendations	August 19, 2014
4A-CF-00-14-039	OPM's FY 2014 Consolidated Financial Statements in Washington, D.C.; 4 total recommendations; 3 open recommendations	November 10, 2014
4A-CI-00-14-016	Federal Information Security Management Act for FY 2014 in Washington, D.C.; 29 total recommendations; 16 open recommendations	November 12, 2014
4A-CI-00-14-064	Information Technology Security Controls of the OPM's Dashboard Management Reporting System in Washington, D.C.; 4 total recommendations; 3 open recommendations	January 14, 2015
3A-CF-00-14-049	The 2011 and 2012 Long Island Combined Federal Campaigns in Deer Park, New York; 18 total recommendations; 13 open recommendations	February 11, 2015
3A-CF-00-14-048	The 2011 and 2012 Northern Lights Combined Federal Campaigns in St. Paul, Minnesota; 29 total recommendations; 1 open recommendations	March 23, 2015
4K-RS-00-14-076	The Review of OPM's Compliance with the Freedom of Information Act in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 23, 2015

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Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2017

(Continued)

Report Number	Subject	Date Issued
4A-RS-00-13-033	Assessing the Internal Controls over OPM's Retirement Services' Retirement Eligibility and Services Office in Washington, D.C.; 7 total recommendations; 1 open recommendations	April 13, 2015
4A-CF-00-15-025	OPM's FY 2014 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 4 total recommendations; 2 open recommendations	May 15, 2015
4A-HR-00-13-055	The Human Resources Solutions' Pricing Methodologies in Washington, D.C.; 5 total recommendations; 5 open recommendations	June 2, 2015
4A-CI-00-15-055	Flash Audit Alert—OPM 's Infrastructure Improvement in Washington, D.C.; 2 total recommendations; 1 open recommendation	June 17, 2015
4A-HR-00-15-018	Information Technology Security Controls of OPM's USA Performance System in Washington, D.C.; 1 total recommendation; 1 open recommendation	July 20, 2015
1A-99-00-14-046	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 2 open recommendations	July 29, 2015
4A-RI-00-15-019	Information Technology Security Controls of OPM's Annuitant Health Benefits Open Season System in Washington, D.C.; 7 total recommendations; 6 open recommendations	July 29, 2015
4A-HR-00-15-015	Information Technology Security Controls of OPM's GP Plateau Baseline 6 Learning Management System in Washington, D.C.; 12 total recommendations; 3 open recommendations	July 31, 2015
1C-QA-00-14-045	Independent Health Plan in Buffalo, New York; 3 total recommendations; 2 open recommendations	August 12, 2015
1C-E3-00-15-020	Information Systems General and Application Controls at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in Silver Spring, Maryland; 8 total recommendations; 2 open recommendations	August 28, 2015
1C-22-00-14-071	Aetna Health Fund in Blue Bell, Pennsylvania; 2 total recommendations; 1 open recommendations	August 31, 2015
1C-51-00-14-066	Health Insurance Plan of Greater New York in New York, New York; 3 total recommendations; 2 open recommendations	August 31, 2015
4A-RI-00-16-014	Management Alert of Serious Concerns Related to OPM's Procurement Process for Benefit Programs in Washington, D.C.; 4 total recommendations; 3 open recommendations	October 14, 2015
4A-CI-00-15-011	Federal Information Security Modernization Act of FY 2015 in Washington, D.C.; 27 total recommendations; 17 open recommendations	November 10, 2015

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Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2017

(Continued)

Report Number	Subject	Date Issued
4A-CF-00-15-027	OPM's FY 2015 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 5 open recommendations	November 13, 2015
1A-10-17-14-037	Health Care Service Corporation in Abilene, Texas; 16 total recommendations; 4 open recommendations	November 19, 2015
4K-RS-00-16-024	The OIG's Special Review of OPM's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group LLC, and its subcontractor, CSIdentity in Washington, D.C.; 2 total recommendations; 2 open recommendations	December 2, 2015
1A-99-00-15-008	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 8 total recommendations; 8 open recommendations	January 21, 2016
1C-3A-00-15-012	Information Systems General and Application Controls at AultCare Health Plan in Canton and Columbus, Ohio; 16 total recommendations; 2 open recommendations	January 21, 2016
1C-76-00-15-021	Information Systems General and Application Controls at Union Health Service, Inc. in Chicago, Illinois; 25 total recommendations; 4 open recommendations	February 16, 2016
4K-RS-00-15-050	The Evaluation of OPM's Oversight of the Federal Workers' Compensation Program in Washington, D.C.; 5 total recommendations; 1 open recommendations	March 29, 2016
I-12-00464	Investigation of Improper Contracting Practices in Washington, D.C.; 3 total recommendations; 3 open recommendations	April 29, 2016
1C-2U-00-15-030	Aetna Open Access—Athens and Atlanta in Blue Bell, Pennsylvania; 2 total recommendations; 1 open recommendation	May 10, 2016
1C-HA-00-15-033	Coventry Health Care of Kansas, Inc. in Blue Bell, Pennsylvania; 3 total recommendations; 1 open recommendation	May 10, 2016
4A-CF-00-16-026	OPM's FY 2015 Improper Payments Reporting in Washington, D.C.; 6 total recommendations; 5 open recommendations	May 11, 2016
4A-CI-00-16-037	Second Interim Status Report on OPM's Infrastructure Improvement Project—Major IT Business Case in Washington, D.C.; 2 total recommendations; 2 open recommendations	May 18, 2016
1A-99-00-15-047	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 3 open recommendations	June 17, 2016
4A-CA-00-15-041	OPM's Office of Procurement Operations' Contract Management Process in Washington, D.C.; 6 total recommendations; 6 open recommendations	July 8, 2016
1C-JR-00-15-046	Aetna Open Access—Northern New Jersey in Blue Bell, Pennsylvania; 3 total recommendations; 1 open recommendation	July 15, 2016
1C-L4-00-l6-013	HMO Health Ohio in Cleveland, Ohio; 2 total recommendations; 2 open recommendations	September 23, 2016

APPENDIX VIII
Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF MARCH 31, 2017

(Continued)

Report Number	Subject	Date Issued
1H-04-00-15-053	American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts Holding Company for Contract Years 2012 through 2014 in Washington, D.C.; 13 total recommendations; 8 open recommendations	September 28, 2016
1D-89-00-16-011	Information Systems General and Application Controls at Triple-S Salud, Inc. in San Juan, Puerto Rico; 13 total recommendations; 2 open recommendations	September 28, 2016
4K-RS-00-16-023	OPM's Retirement Services' Customer Service Function in Washington, D.C.; 3 total recommendations; 3 open recommendations	September 28, 2016

*Note: Visit **https://www.opm.sov/our-inspector-general/** for the report of outstanding unimplemented recommendations.*

APPENDIX IX
Most Recent Peer Review Results

AS OF MARCH 31, 2017

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

Subject	Date of Report	Result
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization *(Issued by the Office of the Special Inspector General for Afghanistan Reconstruction)*	September 22, 2015	Pass[3]
System Review Report on the Amtrak Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	January 29, 2016	Pass[3]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Railroad Retirement Board *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	August 13, 2014	Compliant[4]
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, U.S. Department of State)*	December 2, 2016	Compliant[4]

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

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

APPENDIX X
Investigative Recoveries
OCTOBER 1, 2016 TO MARCH 31, 2017

OIG Case Number	Case Category	Action	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2008 00096	Healthcare Fraud	Civil Action	$ 202,574	$28,125,000	$ 0
I 2009 00123	Healthcare Fraud	Sentenced	348,158	1,901,780	1,200
I 2010 00534	Healthcare Fraud	Civil Action	43,951	146,475	0
I 2010 00534	Healthcare Fraud	Civil Action	1,101	2,695	0
I 2010 00534	Healthcare Fraud	Civil Action	1,675	5,000	0
I 2010 00534	Healthcare Fraud	Civil Action	15,410	60,532	0
I 2010 00534	Healthcare Fraud	Civil Action	0	0	0
I 2010 00534	Healthcare Fraud	Civil Action	0	0	0
I 2010 00534	Healthcare Fraud	Civil Action	0	0	0
I 2010 00534	Healthcare Fraud	Civil Action	0	0	0
I 2010 00539	Healthcare Fraud	Civil Action	62,766	190,000	0
I 2011 00782	Healthcare Fraud	Civil Action	29,488	4,000,000	0
I 2011 00829	Healthcare Fraud	Sentenced	0	0	38,338
I 2011 00829	Healthcare Fraud	Sentenced	0	0	10,100
I-12-00333	Healthcare Fraud	Sentenced	92,379	615,000	0
I-12-00342	Healthcare Fraud	Sentenced	392,604	7,365,481	700
I-12-00381	Healthcare Fraud	Sentenced	1,215,273	4,960,296	100
I-13-00003	Healthcare Fraud	Civil Action	354,396	394,824	0
I-13-00745	Healthcare Fraud	Civil Action	138,277	20,000,000	0
I-13-01055	Healthcare Fraud	Civil Action	6,305	31,000	0
I-14-00344	Healthcare Fraud	Pre-trial Diversion	17,431	17,431	1,000
I-14-00436	Healthcare Fraud	Civil Action	0	18,017,383	0
I-14-00891	Healthcare Fraud	Civil Action	326,053	369,717	0
I-14-01112	Healthcare Fraud	Sentenced	0	0	600
I-15-00156	Healthcare Fraud	Sentenced	143,111	143,111	100
I-15-00194	Healthcare Fraud	Sentenced	0	0	100
I-15-00412	Healthcare Fraud	Sentenced	0	0	100
I-15-00412	Healthcare Fraud	Sentenced	0	4,357,433	100
I-15-00412	Healthcare Fraud	Sentenced	0	19,980,987	100

APPENDIX X
Investigative Recoveries
OCTOBER 1, 2016 TO MARCH 31, 2017

(Continued)

OIG Case Number	Case Category	Action	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I-15-00412	Healthcare Fraud	Sentenced	$ 0	$ 4,469,753	$ 2,600
I-15-00434	Healthcare Fraud	Civil Action	25,259	750,000	0
I-16-00447	Healthcare Fraud	Civil Action	1,248	124,000	0
I-16-00690	Healthcare Fraud	Civil Action	34,363	12,500,000	0
I-16-00780	Healthcare Fraud	Civil Action	470,450	60,000,000	0
I-17-00024	Healthcare Fraud	Civil Action	746	180,065	0
I-17-00076	Healthcare Fraud	Civil Action	0	815,794	0
I-17-00076	Healthcare Fraud	Civil Action	2,270	971,903	0
I-17-00076	Healthcare Fraud	Civil Action	6,564	602,335	0
TOTAL	Healthcare Fraud		$ 3,931,852	$191,097,995	$55,138
I-17-00105	Life Insurance Fraud	Sentenced	0	248,477	0
TOTAL	**Life Insurance Fraud**		**$ 0**	**$248,477**	**$0**
I-12-00725	National Background Investigations Bureau Fraud	Sentenced	264,312	264,312	100
TOTAL	**National Background Investigations Bureau Fraud**		**$ 264,312**	**$264,312**	**$ 100**
I-12-00647	Contractor Fraud	Sentenced	43,706	70,646	100
TOTAL	**Contractor Fraud**		**$ 43,706**	**$70,646**	**$ 100**
I-13-00542	Retirement Fraud	Financial Recovery	52,137	52,137	0
I-14-01218	Retirement Fraud	Pre-trial Diversion	60,874	60,874	0
I-15-00634	Retirement Fraud	Civil Action	112,714	116,200	0
I-15-01069	Retirement Fraud	Financial Recovery	109,622	109,621	0
I-16-00479	Retirement Fraud	Sentenced	2,899	14,686	25
TOTAL	**Retirement Fraud**		**$ 338,246**	**$353,518**	**$25**
GRAND TOTAL			**$4,578,116**	**$192,034,948**	**$55,363**

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

Index of Reporting Requirements

(INSPECTOR GENERAL ACT OF 1978, AS AMENDED)

OIG Hotline

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For additional information or copies of this publication, please contact:

OFFICE OF THE INSPECTOR GENERAL
United States Office of Personnel Management

Theodore Roosevelt Building
1900 E Street, N.W., Room 6400Washington, DC 20415-1100
Telephone: (202) 606-1200
Fax: (202) 606-2153

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