SEMIANNUAL REPORT TO CONGRESS

APRIL 1, 2021–SEPTEMBER 30, 2021

U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL

PRODUCTIVITY INDICATORS

FINANCIAL IMPACT

Audit Recommendations for Recovery of Funds
$22,263,056

Management Commitments to Recover Funds
$9,941,394

Recoveries Through Investigative Actions $2,435,090

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

ACCOMPLISHMENTS

16 Audit Reports Issued

Evaluation Reports Issued 1

Data Briefs Issued 0

Management Advisories Issued 1

70 Investigations and Preliminary Investigations Closed

Indictments and Criminal Informations 10

7 Arrests

14 Convictions

1,287 Hotline Contacts and Complaints Received

Hotline Contacts and Complaints Closed 1,426

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

37,331 **Debarment and Suspension Inquiries Regarding Federal Employees Health Benefits Program's Providers**

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

On June 22, 2021, the United States Senate confirmed Kiran A. Ahuja as the Director of the U.S. Office of Personnel Management (OPM). We would like to extend a warm welcome to Director Ahuja. Since she began her tenure, she has been accessible and supportive of the work of the Office of the Inspector General (OIG). I am looking forward to continuing an open and frequent dialogue with her and her senior staff. We have already begun critical discussions regarding ways in which we can work together to promote the efficiency and effectiveness of OPM's programs and operations. Specifically, she and I share an interest in addressing two issues the OIG has long considered top priorities: OPM's improper payments reporting and OPM's open recommendations.

OPM reports improper payments for two of its earned benefits programs: Retirement Services (RS), and the Federal Employees Health Benefits Program (FEHBP). In fiscal year 2020, OPM reported improper payment rates of 0.36 percent for RS and 0.05 percent for the FEHBP. However, as we have previously reported, the OPM OIG believes these figures to be understated.[1] We have consistently identified vulnerabilities in program integrity and oversight that allow for improper payments to go unidentified and underreported, harm the financial integrity of OPM programs, and cost taxpayer dollars. While we are encouraged by recent dialogue between OPM senior leadership and our office concerning these issues, no substantive changes have been agreed to yet. We truly welcome Director Ahuja's attention to these critical issues.

Like the longstanding improper payment issues, the OIG is equally alarmed by the number of outstanding open recommendations resulting from OIG audits and evaluations. We are particularly concerned by the age of some of the recommendations. Currently, 38 of the 396 open recommendations are over 5 years old half of which are unique, and several that date back to 2008 and 2009. In fact, OPM's rate of closure for recommendations remains well below the rate needed to keep up with new recommendations. The number of open recommendations older than 6 months has almost doubled in 4 years, increasing from 214 as of September 30, 2017, to 396 as of September 30, 2021.

Even so, we are encouraged that the agency has recently devoted resources and attention to this issue. From our various meetings with OPM, it appears that leadership understands the issue and is focused on addressing the problems. For instance, the Chief Information Officer has informed our office that he is placing a new focus on open recommendations and devoting resources and staff who will be tasked with

[1] *See generally* Audit of the U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting (May 17, 2021), Audit of the U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting (May 14, 2020), Audit of the U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting (June 3, 2019), Top Management Challenges: Fiscal Year 2021 (October 16, 2020), Top Management Challenges: Fiscal Year 2020 (November 6, 2019), and Audit of the U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies (April 2, 2020).

closing recommendations. This is significant for many reasons, including the fact that recommendations related to information systems represent 75 percent of total open recommendations older than 6 months and 77 percent of repeated recommendations older than 6 months (as of September 30, 2021). We urge Director Ahuja to take a similar approach with all OPM program offices and make closing open recommendations a top priority.

I look forward to working with Director Ahuja on our shared priorities. I believe that appropriately addressing all aspects of improper payments — prevention, identification, reporting, and recovery — and focusing efforts on implementing corrective actions to close open recommendations are essential to promoting integrity, economy, and effectiveness within OPM's programs and operations.

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

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

In our two most recent semiannual reports, we discussed the impact of COVID-19 on the OPM-administered FEHBP population. Specifically, we discussed trends in COVID-19 testing and diagnoses, the use of preventive care services, and telehealth trends throughout the entirety of calendar year 2020. Because the coronavirus pandemic continues to be a significant concern for the population served by the FEHBP and is leading to new work in both our Audits and Investigations offices, we have again dedicated a portion of our semiannual report to an analysis of COVID-19's impact on the FEHBP population.

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

The data used for our analysis comes from our data warehouse, which includes health insurance claims submitted by participating FEHBP health insurance carriers. Because there is a lag between when medical services are provided and when they are reported to the carriers, there will always be delays in obtaining complete sets of data. Based on our analysis, we believe we have received the vast majority of the claims data through July 2021, though a small number of claims will likely be submitted throughout the remainder of 2021. For this reason, the figures represented in this semiannual report may vary slightly from those reported in previous semiannual reports.

Our analysis of COVID-19 diagnoses shows a relatively steady decline from January to June 2021. Cases sharply increased from June to July, though as we will demonstrate below, this rise has not been uniform across all age groups and locations.

Exhibit 1: Total COVID-19 Diagnoses Per Day (2020–2021)

Please note figures include only a subset of FEHBP Health Plans

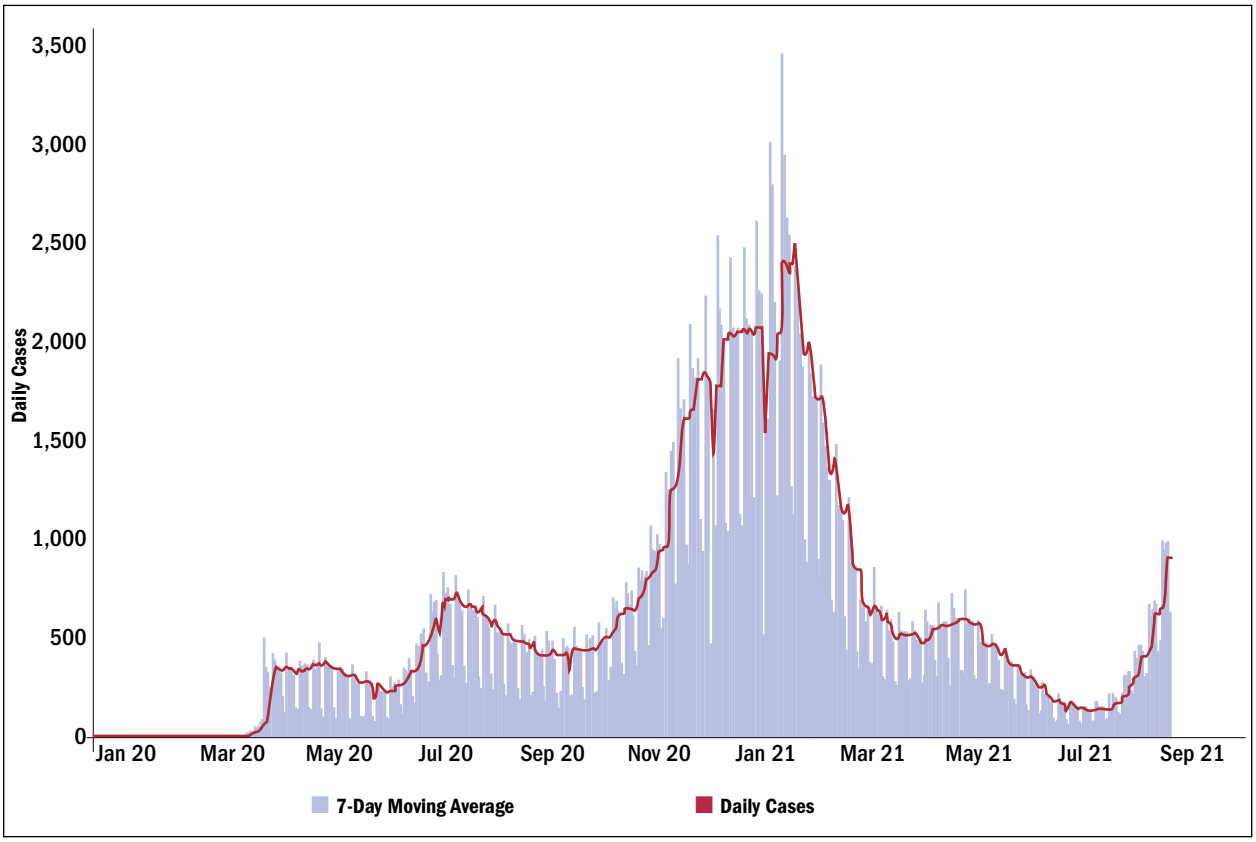

Exhibit 1: Total Diagnoses per Month (2020-2021). This bar graph shows the total COVID-19 diagnoses per day from January 2020 to July 2021. Case numbers dropped steadily from December 2020 to March 2021, held steady through April 2021, then continued to drop through June 2021. Cases began increasing from June to July 2021, jumping back up to about 15,000 diagnoses per day by the end of July 2021.

While we currently only have complete data through July, a comparison of our Exhibit 1 to the Centers for Disease Control and Prevention's (CDC's) daily cases in Exhibit 2 shows that our data closely resembles the CDC's diagnoses trends as reported on its COVID data tracker website.

Exhibit 2: CDC Data on Total Diagnoses Per Day (2020–2021)

Please note figures include only a subset of FEHBP Health Plans

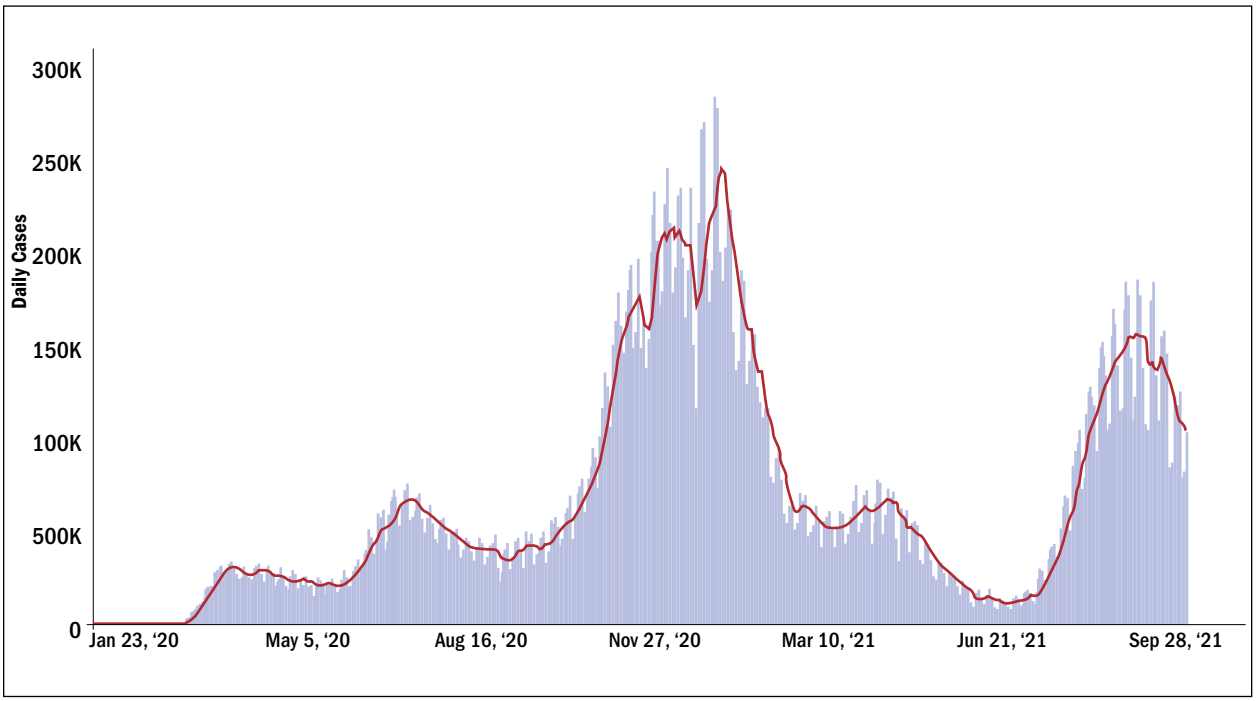

Exhibit 2: Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC. This line graph, taken from the CDC COVID Data Tracker website, shows the total COVID-19 diagnoses per day from January 2020 to September 2021. Case numbers dropped steadily from December 2020 to February 2021, peaked slightly in March and April 2021, then continued to drop through July 2021. Cases began rising sharply after July 2021 and were around 150,000 cases per day as of September 13, 2021.

Because the trend in COVID-19 diagnoses in the FEHBP continues to follow the same general trend occurring in the overall U.S. population, we expect that COVID-19 cases in the FEHBP population have continued to rise in August and September.

An analysis of our data showed that only 7.09 percent of FEHBP enrollees were fully vaccinated as of July 31, 2021. This number is so drastically low that we do not believe it is a correct representation of reality. Rather, we believe this is a result of the nature of the data we receive from the health carriers and the distribution methods of the vaccine. The data used in our analysis is FEHBP health insurance claims data. Many, if not most, individuals who received COVID-19 vaccines never had a claim filed on their behalf for this service because the vaccines were funded by the Government and largely distributed by volunteers or Government-sponsored groups, such as the National Guard. Therefore, those vaccinations would not be reflected in our data.

Cases sharply increased from June to July; however, as we will demonstrate below, this rise has not been uniform across all age groups and locations.

First, the trend in diagnoses per age group may suggest that more highly-vaccinated age groups are seeing lower rates of COVID-19 diagnoses. The rate of COVID-19 cases in FEHBP members older than 50 has seen a slight decrease since February/March of 2021, and has not experienced the same rise in cases seen in members younger than 24.

In the chart below, we examine the proportion of COVID-19 cases per age group to the proportion of FEHBP enrollees in that age group over time. For example, if an age group makes up 10 percent of the FEHBP population and the number of cases in that age group makes up 10 percent of total FEHBP cases, the proportion for that age group for that month will be equal to 1. However, if that same age group accounts for 20 percent of the total FEHBP cases in a given month, its proportion would be equal to 2.

Exhibit 3: Rate of COVID-19 Diagnoses Per Age Group, Relative to Proportion of FEHBP Population (2020–2021)

Please note figures include only a subset of FEHBP Health Plans

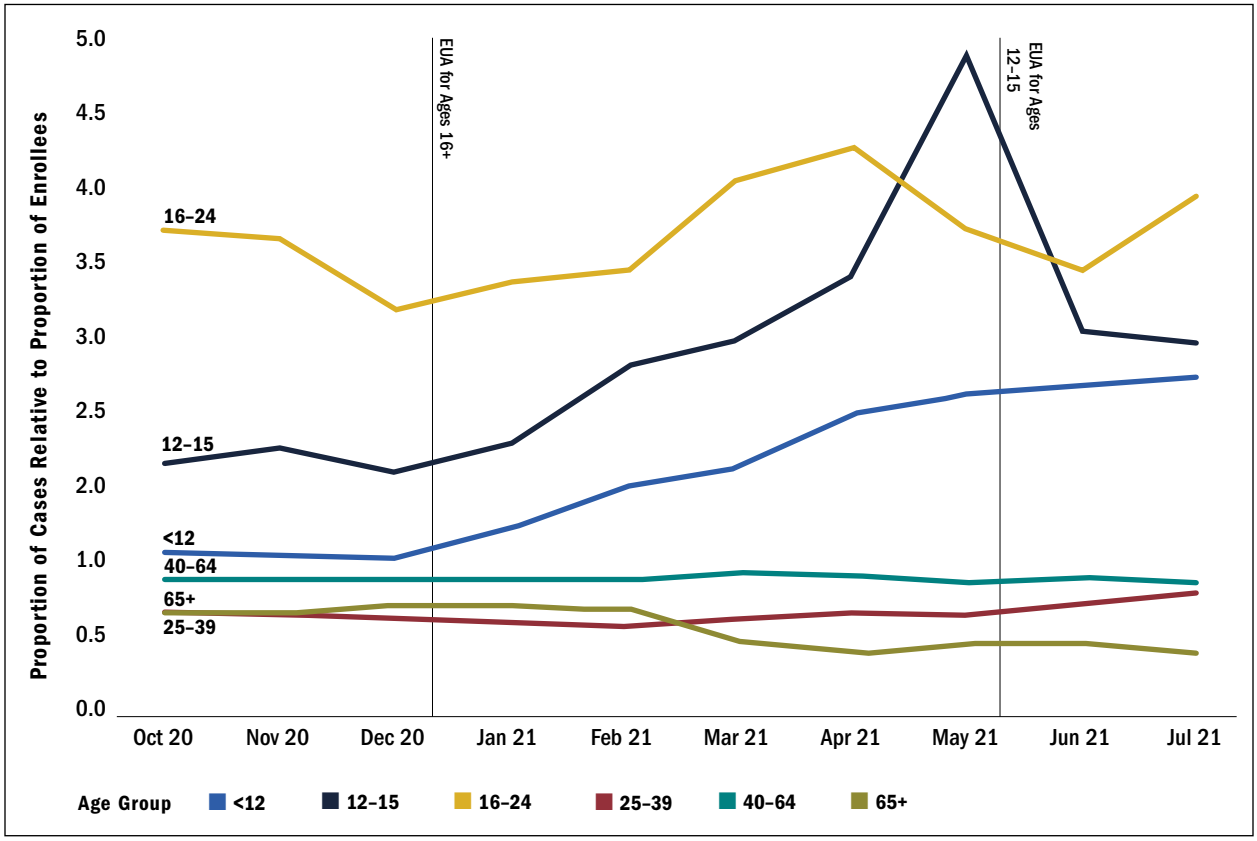

Exhibit 3: Rate of COVID-19 Diagnoses per Age Group, Relative to Proportion of FEHBP Population (2020–2021). This multi-line graph shows the trend in COVID-19 diagnoses per month from October 2020 to July 2021, with a separate line for each age group. The lines for age groups younger than 12 and ages 12–15 remain relatively steady from October to December 2020, then rise from December 2020 to May 2021. After May 2021, the line for age groups younger than 12 continues to rise slightly, while the line for ages 12–15 drops drastically from May to June 2021 and drops again slightly from June to July 2021. Age group 16–24 begins by decreasing from October to December 2020, then rising slowly through April 2021, dropping from April to June 2021, then rising again in July. The lines for individuals ages 25–39, 40–64, and 65 and older remain relatively steady from October 2020 to February 2021, at which point the individuals ages-65-and-older line begins dropping, only rising very slightly in May and June 2021 before dropping again in July 2021. The line for individuals ages 25–39 rises slightly from February to July 2021, never exceeding the expected proportion of cases. The line for individuals ages 40–64 remains steady right around the expected proportion of cases for the age group throughout the entire period. Also included on the chart are two date markers: one on December 11, 2020, marking the EUA for COVID-19 vaccines for individuals ages 16 and older, and another on May 10, 2021, for EUA approval of COVID-19 vaccines for ages 12–15.

As we can see, enrollees ages 40–64 make up their expected proportion of FEHBP cases for the entire period examined. Enrollees 25–39 and enrollees 65 and older make up less than their expected proportion of cases for the entire period, with individuals 65 and older dropping even lower after February. Meanwhile, enrollees 24 and younger make up a greater than expected portion of the FEHBP COVID-19 diagnoses, particularly after December.

Two dates of note are marked with vertical lines on the chart: one line on December 11, 2020, marks when emergency use authorization (EUA) for COVID-19 vaccines for individuals ages 16 and older was granted; and the other line on May 10, 2021, marks the date when EUA was granted for children ages 12–15. There is a noticeable rise in the proportion of cases in ages 24 and younger after the first EUA and a noticeable drop in ages 12–15 after the second.

It is important to note that while emergency use for the first COVID-19 vaccines in the U.S. was authorized for individuals ages 16 and older in December 2020, this did not result in all individuals 16 and older having immediate access to the vaccines. Vaccines were distributed in phases according to varied rollout plans in different States and even counties. This may account for the rise in the proportion of cases in the 16–24 age group from December to April and the subsequent drop in cases after April, which was about the time vaccines were widely available to individuals in this age group.

That being said, there remain unanswered questions regarding some of these trends, such as the rise in the proportion of cases in the 16–24 age group between June and July, and the lack of a drop in ages 25–39 and 40–64 once vaccines became available. While we do not have the data to explain each of these trends precisely in detail, the bigger picture provides a clearer view: in general, age groups with higher vaccination rates make up a lower proportion of COVID-19 cases among FEHBP enrollees.

In addition to the disparities in age groups, we are also beginning to see disparities in the numbers of diagnoses in each State. When comparing the number of COVID-19 diagnoses in each State per month (according to our data) to the percent of the population vaccinated in those States (according to CDC data), the prevalence of FEHBP COVID-19 diagnoses appears to be decreasing more rapidly in those States with higher vaccination rates. For example, Vermont, Massachusetts, and Maine are three of the most vaccinated States, and we are seeing similar drastic decreases in cases in each of these States, even through July as nationwide cases were rising.

Exhibit 4: CDC Data on Vaccination Percentages Per State (as of July 31, 2021)

Please note figures include only a subset of FEHBP Health Plans

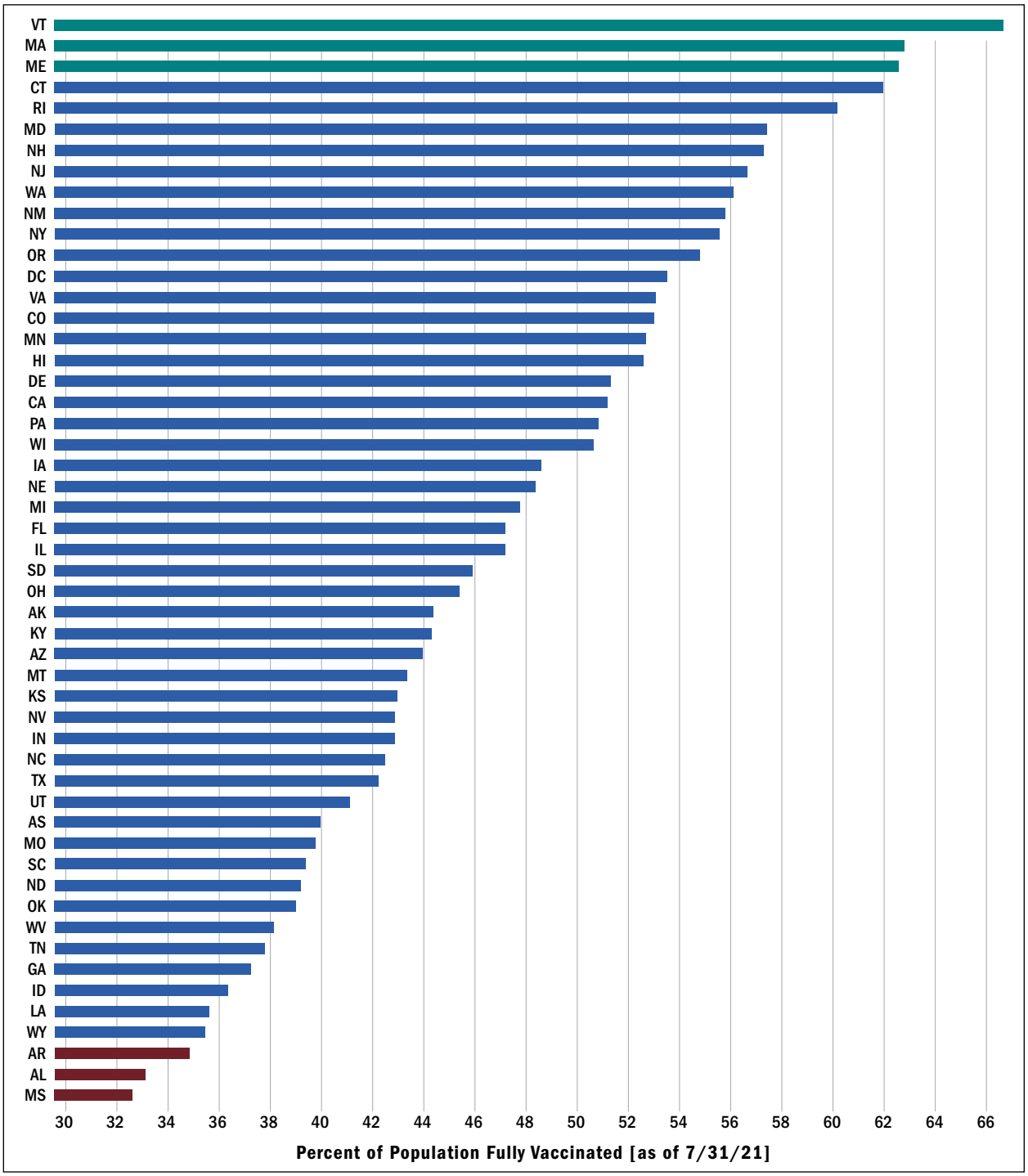

Exhibit 4: CDC Data on Vaccination Percentages per State (as of July 31, 2021). This horizontal bar graph shows the percentage of the population vaccinated in each U.S. State, the District of Columbia, and American Samoa, as of July 31, 2021. The top three States in order are Vermont, Massachusetts, and Maine, each with over 60 percent of the State population vaccinated. The bottom three States are Arkansas, Alabama, and Mississippi, each with less than 36 percent of the State population vaccinated. The remaining States fall somewhere in the middle.

Exhibit 5: Trend in COVID-19 Vaccinations and Diagnoses – Vermont

Please note figures include only a subset of FEHBP Health Plans

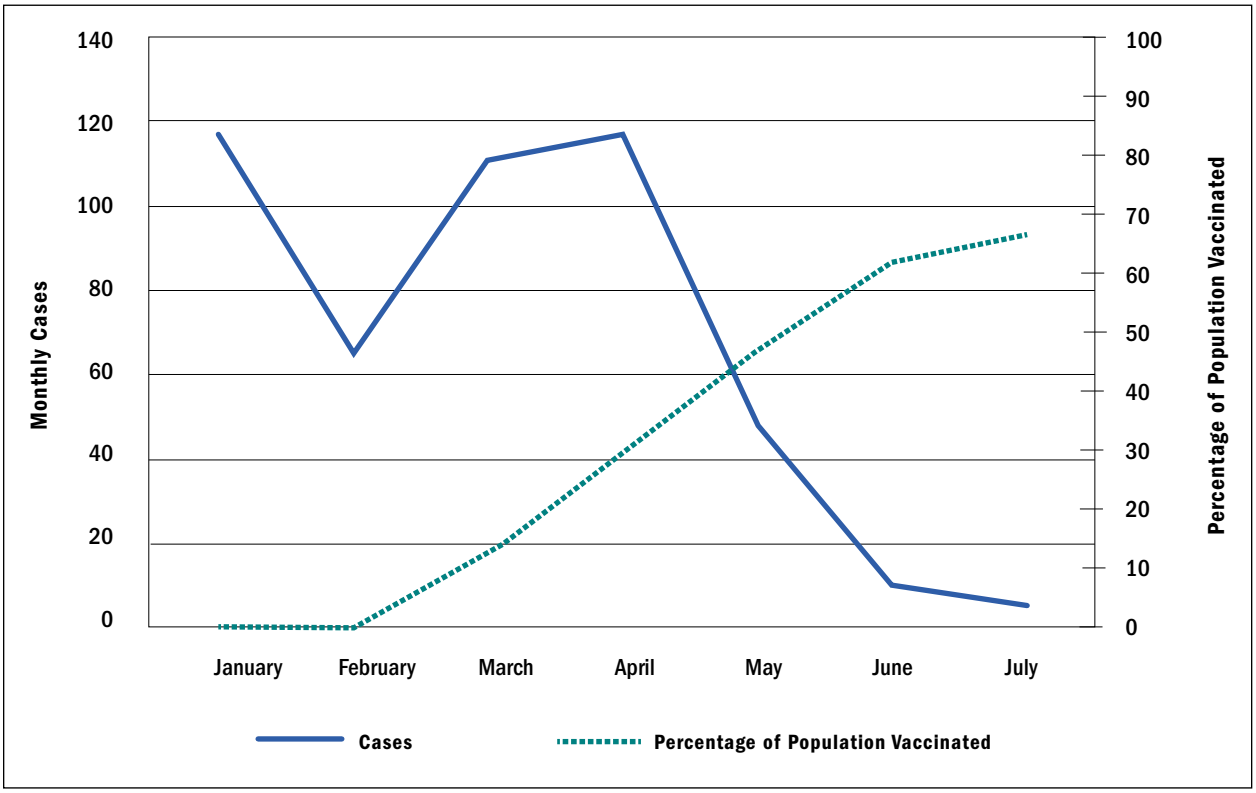

Exhibit 5: Trend in COVID-19 Vaccinations and Diagnoses – Vermont. This line graph shows one line for monthly COVID-19 cases and one for the percentage of the population vaccinated. The line for cases drops drastically after April 2021, nearly zeroing out in July 2021. In contrast, the line for percentage of population vaccinated rises sharply from February through July 2021, ending around 67 percent.

We are only presenting a graph of Vermont's trends in COVID-19 vaccinations and diagnoses, as the graphs for Massachusetts and Maine look very similar.

In contrast, Mississippi, Alabama, and Arkansas are the three States with the lowest vaccination rates. Unlike the three most vaccinated States mentioned above, these three are all experiencing similar resurgences in COVID-19 diagnoses starting in July. As with the three States with the highest vaccination rates, we are only showing a graph of data for one State (Mississippi) here, as the graphs for Alabama and Arkansas are very similar.

Exhibit 6: Trend in COVID-19 Vaccinations and Diagnoses – Mississippi

Please note figures include only a subset of FEHBP Health Plans

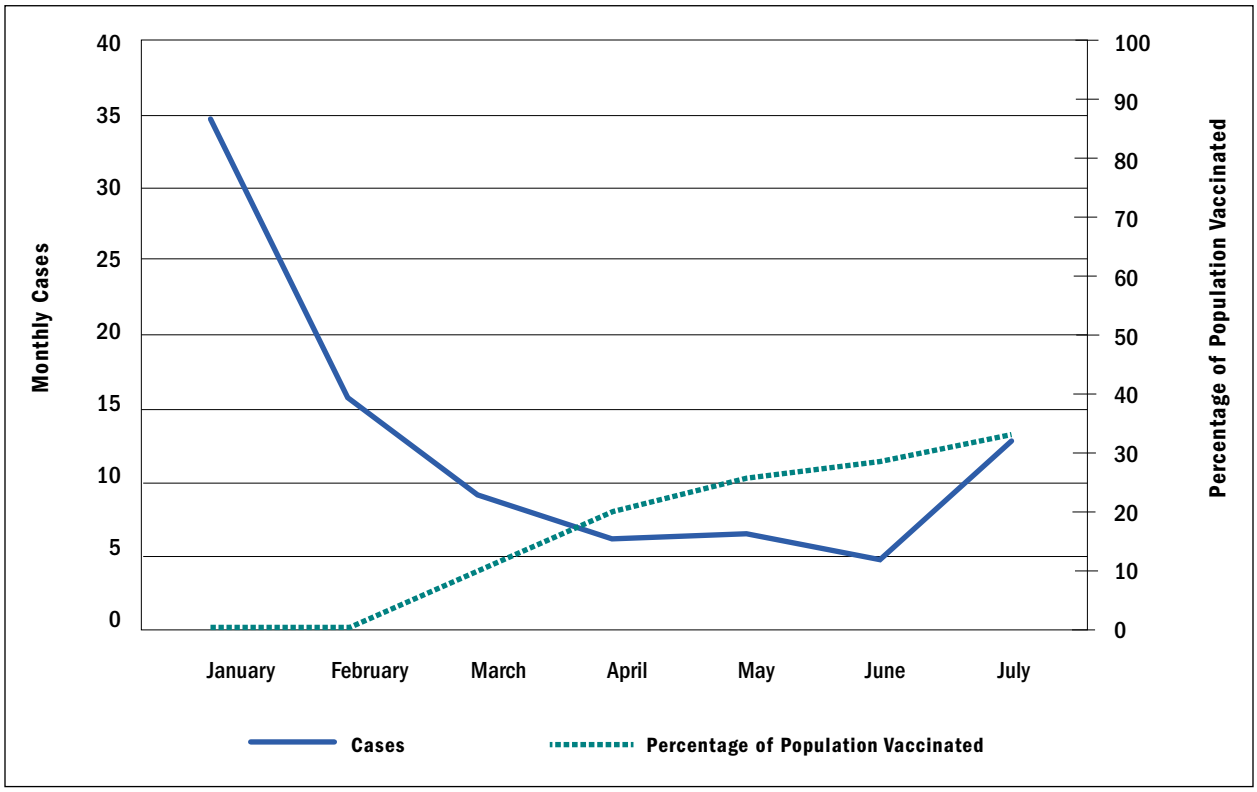

Exhibit 6: Trend in COVID-19 Vaccinations and Diagnoses – Mississippi. This line graph shows one line for monthly COVID-19 cases and one for the percentage of the population vaccinated. The line for cases drops drastically from January to April 2021, rises very slightly in May, drops in June, increases sharply in July. The line for percentage of population vaccinated rises from February to July 2021, but only reaches about 33 percent.

These two trends combined suggest vaccination rates amongst FEHBP members probably follow the national levels reported by the CDC more closely than our claims data reflects. Of course, correlation does not equal causation, and there could be unseen factors at play here. If cases in the FEHBP have been rising at the same rate as the national data since July, our next semiannual report should give a clearer picture of any divide between States with higher and lower vaccination rates over time.

Continued Impacts to Preventive Care Due to COVID-19

In our last two semiannual reports, we expressed concerns regarding preventive care utilization by FEHBP members. In our last semiannual report, we demonstrated that preventive care utilization had increased significantly after the first half of 2020, but utilization rates in the second half of the year were still not high enough to offset the missed procedures. This continues to be the case.

The number of individuals covered by the FEHBP health care carriers included in our analysis increased by 1.54 percent from 2019 to 2020. We now know that there was an additional 1 percent increase in

covered individuals from 2020 to 2021. As such, we should see an increase in preventive care utilization of about 2–3 percent for 2021, as compared to pre-pandemic levels in 2019. Keep in mind this increase in utilization would appear to be a return to normal levels but would not necessarily make up for all the missed procedures in 2020. So far, this expected increase has only been observed in March and June of this year, coinciding with the periods of lowest COVID-19 diagnoses. If this trend continues, we may see additional drops in care as cases began increasing in late summer. We will continue to analyze and report on preventive care utilization as the pandemic continues.

Exhibit 7: Preventive Care Claims Per Month Compared by Year (2019–2021)

Please note figures include only a subset of FEHBP Health Plans

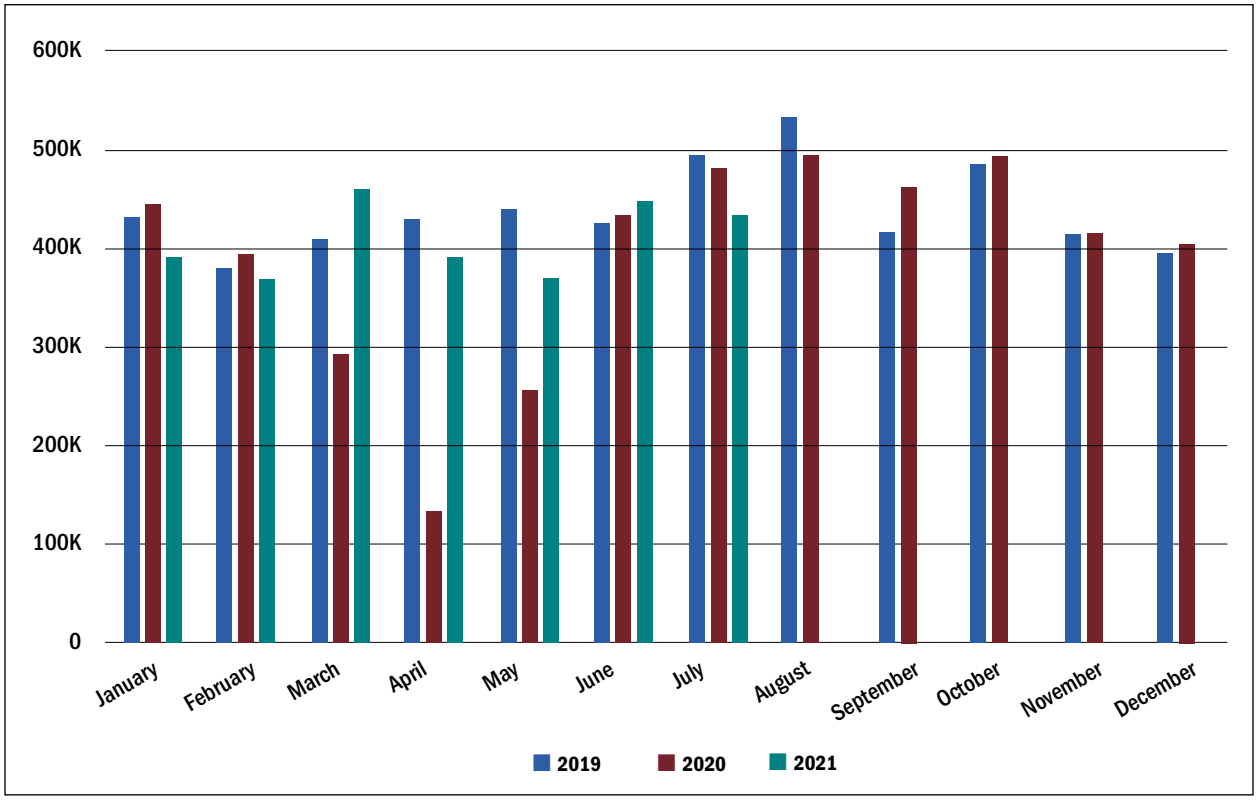

Exhibit 7: Preventive Care Claims per Month Compared by Year (2019–2021). This multi-bar graph shows the number of preventive care claims per month for the years 2019–2021. Compared to 2019, the bars for 2020 are slightly higher in January and February, drastically lower in March, April, and May, slightly higher in June, slightly lower in July and August, significantly higher in September, and slightly higher in October through December. Data for 2021 is only shown through July. Compared to 2019, the bars for 2021 are significantly higher in March and slightly higher in June but are otherwise notably lower.

Further, while some types of services are returning closer to pre-pandemic levels, others are not coming close. Rates of pediatric immunizations, in particular, continue to be observed at lower rates than those seen in 2019.

Exhibit 8: Overall Pediatric Immunization Rate (2019–2021)

Please note figures include only a subset of FEHBP Health Plans

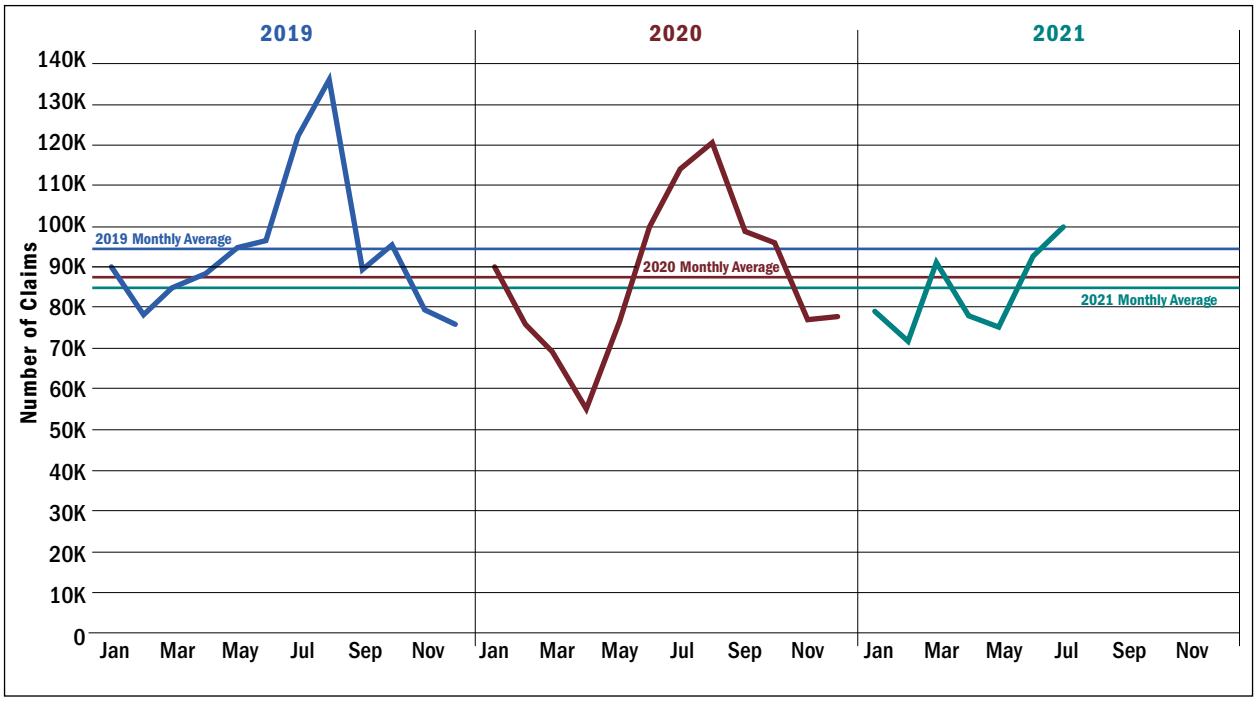

Exhibit 8: Overall Pediatric Immunization Rate (2019–2021). This line graph shows the trend in the number of claims for pediatric immunizations from January 2019 to July 2021. There are average bars for the average number of monthly claims for 2019, 2020, and 2021. The average for 2020 between 85,000 and 90,000) is significantly lower than for 2019 (around 95,000) and the average for 2021 (around 85,000) is slightly lower than the average for 2020.

Pediatric immunizations for diseases of top concern, such as measles, pertussis, and HPV remain well below pre pandemic levels.

This is no longer a new or unrecognized phenomenon. It has been reported by the American Academy of Pediatrics, the World Health Organization, the CDC, and even The Washington Post. However, we find it important to note that even though lockdowns have ended in the U.S. and COVID-19 vaccinations are now available to most individuals, these concerning trends have not been completely righted.

This can be demonstrated by examining several of the most essential types of childhood vaccinations for this generation. When looking at January through July 2021, immunizations for pertussis (including TDaP and DTaP vaccines) fell 20 percent and 7 percent, respectively, from 2019 to 2020. When comparing January

to July of 2021 versus the same months in 2020, the rate of TDaP administrations rebounded somewhat, but remains 7 percent lower than 2019. Meanwhile, DTaP fell further, ending up 8 percent lower than 2019.

Meanwhile, immunizations for measles (including MMR and MMRV vaccines) fell 24 percent and 13 percent from 2019 to 2020. The MMR vaccine fell another 2 percent from 2020 to 2021, ending up 26 percent lower than the 2019 rate. The MMRV vaccine, on the other hand, slightly increased in administrations from 2020 to 2021, but remains 9 percent lower than the 2019 rate.

Exhibit 9: Key Pediatric Vaccine Information[2, 3]

Please note figures include only a subset of FEHBP Health Plans

KEY PEDIATRIC VACCINES

Disease	Disease Complications	Applicable Vaccines	Recommended Age	Percent Drop	
				2019 to 2020	2019 to 2021
Pertussis (whopping cough)	Pneumonia, convulsions, brain damage, death	TDaP	During Pregnancy	20%	7%
		DTaP	5 doses at ages: 2 months 4 months 6 months 15–18 months 4–6 years	7%	8%
Measles	Encephalitis (brain swelling), pneumonia, death	MMR	2 doses at ages: 12–15 months 4–6 years	24%	26%
		MMRV	2 doses at ages: 12–15 months 4–6 years	13%	9%

[2] https://www.cdc.gov/vaccines/parents/downloads/parent-ver-sch-0-6yrs.pdf

[3] https://www.cdc.gov/vaccines/hcp/vis/vis-statements/dtap.html

In addition to those discussed above, another important childhood vaccine following this concerning trend is the human papillomavirus (HPV) vaccine. HPV is the most common sexually transmitted infection in the United States.[4] While the infection usually goes away on its own, it can cause a number of different types of cancer, including cancers of the cervix, penis, and back of the throat. It usually takes years or even decades for cancer to develop after a person contracts HPV[5] and early detection is not possible for all types of cancers caused by HPV.[6]

The positive news is that HPV vaccines have been shown to be safe and effective.[7] According to the CDC, almost all cervical cancer can be prevented by HPV vaccination.[8]

Unfortunately, the rate of this immunization in children enrolled in the FEHBP fell 22 percent from 2019 to 2020, and remains 4 percent lower in 2021 than 2019. Remember, this means the rate is about 6–7 percent lower than we would expect to see if the rate remained the same, given the increase in FEHBP enrollees from 2019 to 2021.

[4] https://www.cdc.gov/std/hpv/stdfact-hpv.htm

[5] https://www.cdc.gov/hpv/parents/cancer.html

[6] https://www.cdc.gov/hpv/parents/vaccine/six-reasons.html

[7] https://www.cdc.gov/hpv/parents/vaccinesafety.html

[8] https://www.cdc.gov/hpv/parents/cancer.html

Exhibit 10: Trend in Pediatric HPV Immunizations (2019–2021)

Please note figures include only a subset of FEHBP Health Plans

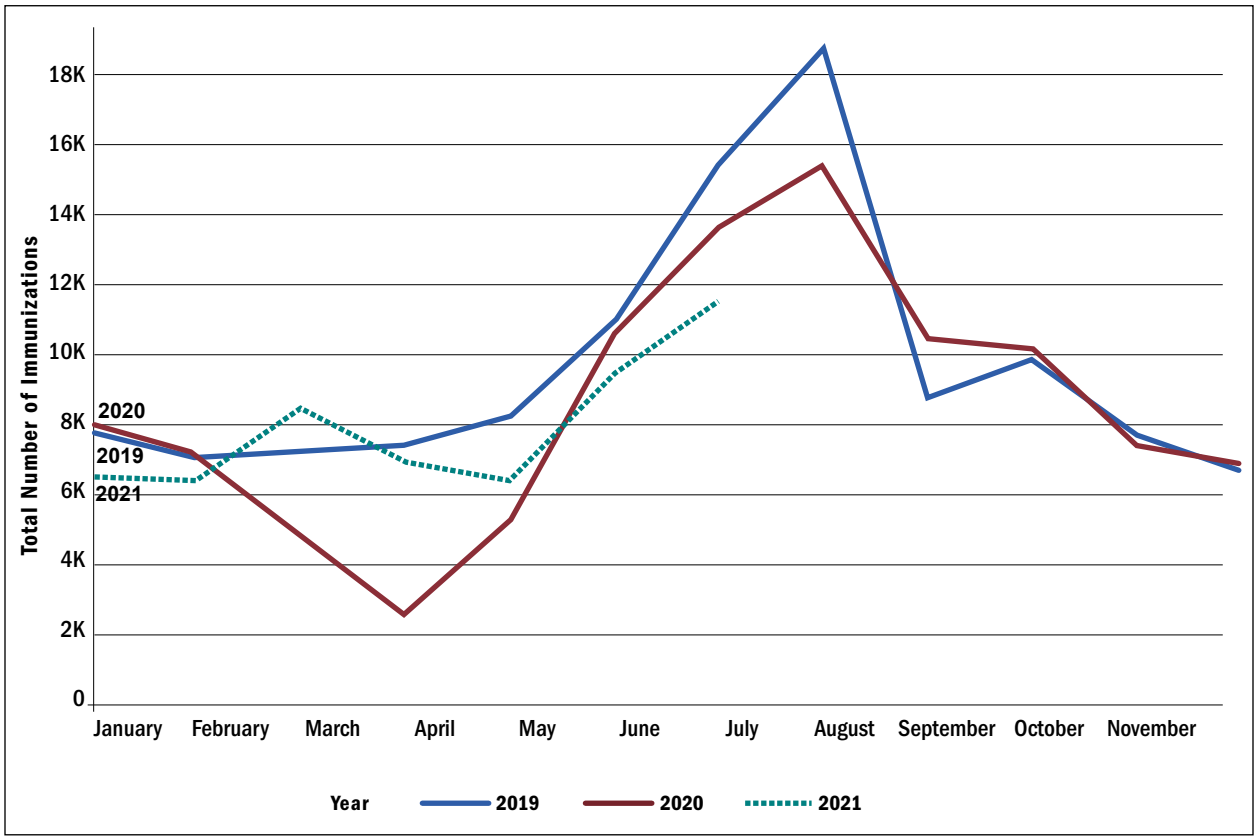

Exhibit 10: Trend in Pediatric HPV Immunizations (2019-2021). This line graph shows three lines representing the total number of HPV vaccinations, with one line for 2019, one for 2020, and one for 2021. The line for 2020 is higher than the line for 2019 only in January, September, October, and December. The line for 2021 is higher than 2019 only in March.

In addition to the health risks mentioned above, this trend is of particular concern in regards to HPV, because immunization rates for this virus were already low, even before the pandemic began. In 2019, the CDC reported that only 54.2 percent of teens ages 13–17 had completed the HPV vaccination series.[9] The CDC, among other organizations, has been making great efforts to increase this percentage. It has a webpage dedicated to helping healthcare professionals boost HPV vaccination rates in their practices and issues awards to medical practitioners who go above and beyond to increase HPV vaccination rates in their communities.

We continue to be concerned about pediatric immunization trends and will continue monitoring pediatric immunization utilization on an ongoing basis.

[9] https://www.cdc.gov/mmwr/volumes/69/wr/mm6933a1.htm

Telehealth

In our last semiannual report, we reported that telehealth utilization in the FEHBP increased nearly 6,000 percent from 2019 to 2020. In 2021, telehealth utilization does appear to be decreasing compared to 2020. However, the FEHBP still has about 400,000 telehealth claims per month, compared to nearly zero pre-pandemic.

Exhibit 11: Trend in Telehealth Claims from January 2019–July 2021

Please note figures include only a subset of FEHBP Health Plans

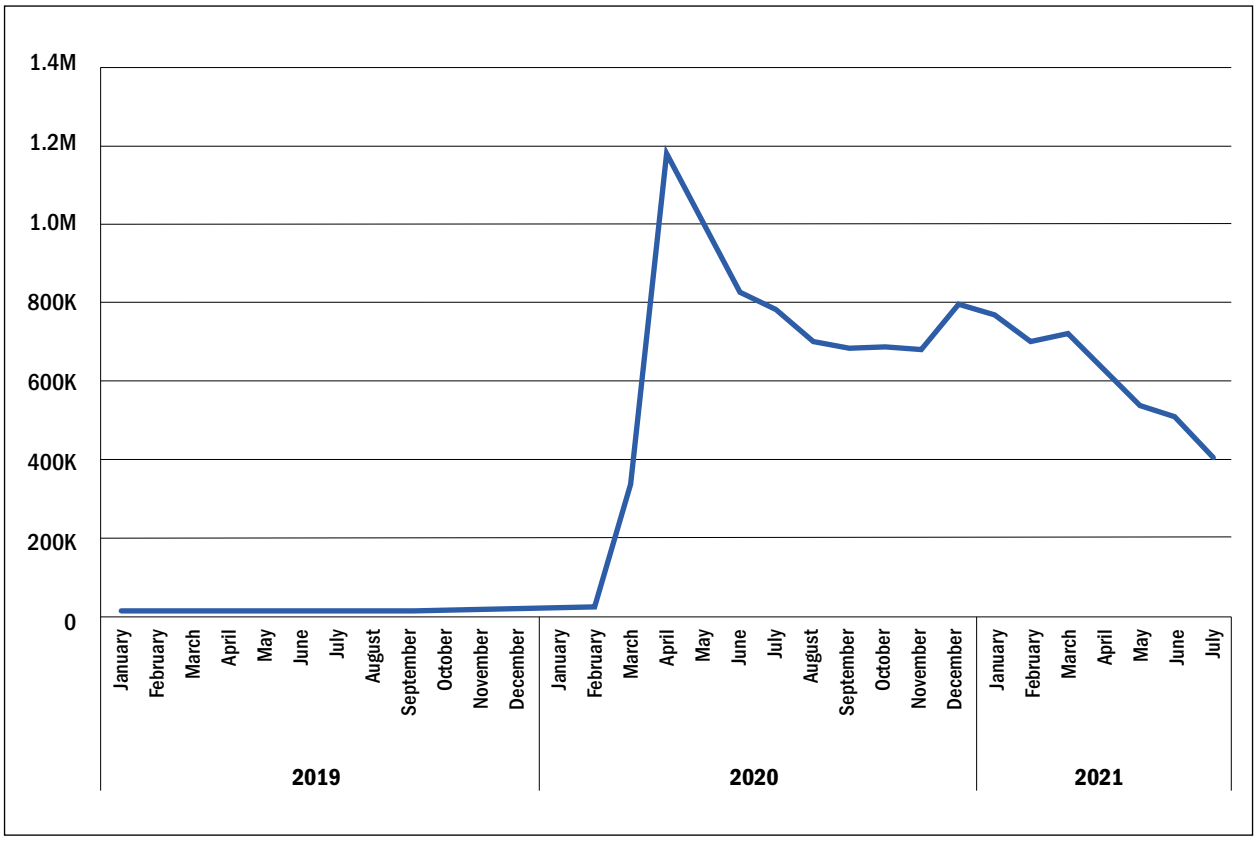

Exhibit 11: Trend in Telehealth Claims from January 2019 to July 2021. This line graph depicts the trend in telehealth claims from January 2019 to July 2021. The line graph almost touches the zero axis for most of 2019, rising slightly in December 2019 through February 2020. After February 2020, the line peaks drastically in March and April 2020, rising above 1 million claims per month. The line then falls from April to June 2020, remains steady at about 600,000 through November, then rises slightly in December 2020. Telehealth claims stayed between 600,000 and 700,000 per month from January to March 2021, then began falling in April. As of July 2021, we are seeing about 400,000 telehealth claims per month.

Telehealth utilization has fluctuated as COVID-19 cases rise and fall across the country. If COVID-19 cases in the FEHBP have been rising at the same rate as the national data since July, it is possible telehealth utilization rates could rise again as the year continues. In addition, we may see an increased number of telehealth claims throughout the winter, as we did this previous winter. Of course, it is currently too early to tell. Either way, it still seems telehealth is here to stay for the foreseeable future.

MISSION STATEMENT

MISSION

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

VISION

Oversight through innovation.

CORE VALUES

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

OIG OFFICE LOCATIONS

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AUDIT ACTIVITIES

Health Insurance Carrier Audits

The U.S. Office of Personnel Management (OPM) contracts with Federal Employees Health Benefits Program (FEHBP) carriers for health benefit plans for Federal employees, annuitants, and their eligible family members. The Office of Audits is responsible for auditing the activities of these health plans to ensure that they meet their contractual obligations with OPM. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the health insurance carrier, the time elapsed since the last audit, and our previous audit results.

The Office of the Inspector General (OIG) insurance audit universe encompasses over 200 audit sites consisting of health insurance carriers, sponsors, and underwriting organizations participating in the FEHBP. The number of audit sites fluctuates due to the addition, nonrenewal, and merger of participating health insurance carriers. Combined premium payments for the FEHBP total over $55 billion annually. The health insurance carriers audited by the OIG are classified as either community-rated or experience-rated.

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

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

FEHBP Program Integrity Risks Due to Contractual Vulnerabilities

Washington, D.C.
Report Number 4A-HI-00-18-026
April 1, 2021

We prepared this Management Advisory Report (MAR) to inform OPM of concerns that the OIG has with various program administration vulnerabilities, as well as contractual vulnerabilities identified

within the health benefit contracts between OPM and the participating FEHBP carriers:

- **Data Issues –** The FEHBP contract documents do not sufficiently address OPM's or the OIG's access to claims data and data retention timeframes, which affects the ability to provide effective program oversight;
- **Fraud, Waste, and Abuse Efforts –** The FEHBP contract documents do not sufficiently address all components needed for a carrier to implement an effective fraud, waste, and abuse program, thus putting the FEHBP at risk of fraudulent payments and, more importantly, putting program members at risk of potential harm;
- **OPM's Fiduciary Responsibilities –** The FEHBP contract documents do not sufficiently address OPM's fiduciary responsibility to ensure that taxpayer dollars are wisely and properly spent; and
- **Other Contract Improvements –** The FEHBP contract documents include clauses that either need to be removed because they are no longer relevant—or amended based on the results of recent audits. In addition, there are clauses that should be added to address vulnerabilities encountered in the performance of our oversight.

This final MAR included 11 procedural recommendations. All recommendations remain open.

Audit of the Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts

Washington, D.C.
Report Number 1H-99-00-20-016
July 29, 2021

We performed an audit of selected FEHBP carriers' pharmacy benefit contracts to determine the reasonableness of each carrier's contractual arrangement with their Pharmacy Benefit Manager (PBM). An additional objective was to determine if the PBM was complying with the PBM Transparency Standards included within each carrier's FEHBP contract with OPM.

Our audit identified two program improvement areas that, if implemented, would lead to savings for the FEHBP and the Federal subscribers:

- Based on discussions with the PBM and our overall review of each carrier's expenses related to the PBM's administration of pharmacy benefits, we believe it would lower FEHBP pharmacy costs if the carriers pooled their resources into a common PBM agreement. Currently, each selected carrier separately contracts with the PBM to provide its members with pharmacy benefits. Our audit disclosed that a carrier's size (lives covered and pharmacy spend) is a major driving factor in the administrative fee rates and pharmacy discounts made available. Simply stated, smaller carriers pay higher administrative fees and receive lower discounts; and
- Our review of claims from the selected nationwide carriers found that the PBM's contracting practices with these carriers and the pricing and payment of retail pharmacy claims do not appear to meet the PBM transparency standards as established by OPM

in 2011. Specifically, the PBM's interpretation of transparency is to pass through to the carriers and the FEHBP the price that it pays to the retail pharmacies at the time the prescriptions are processed. However, its contracting practices with individual carriers allow it to manipulate the generic and brand name drug price paid at point of sale, allowing the PBM to profit from what is paid for these drugs in a non-transparent manner.

This final report included three procedural recommendations. All recommendations remain open.

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 and the Medical Loss Ratios (MLRs) filed with OPM are in accordance with their respective contracts and applicable Federal laws and regulations.

Updated Subscription Income Report Accounting

Based on questions and findings from prior OIG audits, OPM updated the subscription income and year end accrual processes. The Offices of the Chief Information Officer (OCIO) and Chief Financial Officer (OCFO) documented the processes and concluded that the data included in the subscription income report is complete and accurate. Starting in 2021, this update allowed OPM to mandate the use of its calculated subscription income amount as the premium amount for community-rated carriers to use in the denominator of the MLR filing. Prior to this, FEHBP carriers were allowed to choose between OPM's provided number or their own data because there was a lack of confidence in OPM's accounting system. While the new subscription income process has not yet been fully reviewed by the OIG, the documentation and validation of the subscription income was an important step that OPM took to update the system.

Premium Rate Review Audits

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

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

- The medical and pharmacy claims totals are accurate, and the individual claims are processed and paid correctly;
- The FEHBP rates are developed in a model that is filed and approved with the appropriate State regulatory body or used in a consistent manner for all eligible community groups that meet the same criteria as the FEHBP; and
- The loadings applied to the FEHBP rates are appropriate, reasonable, and consistent.

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 MLR requirement to replace the Similarly-Sized Subscriber Group (SSSG) comparison requirement for most community-rated FEHBP carriers.

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

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

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

The following summary highlights notable audit findings for the two community-rated FEHBP carriers audited during this reporting period.

UPMC Health Plan, Inc.

Pittsburgh, Pennsylvania
Report No. 1C-8W-00-20-017
June 28, 2021

UPMC Health Plan, Inc. (Plan) has participated in the FEHBP since 1988 and provides health benefits to FEHBP members in the Western Pennsylvania area. The audit covered contract years 2014 through 2016. During this period, the FEHBP paid the Plan approximately $225.9 million in premiums.

Numerous errors and insufficient controls around FEHBP specific rating and MLR processes led to questioned costs of $13.8 million and required adjustments to the FEHBP MLR filings.

We determined that portions of the MLR and premium rate review calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in questioned costs totaling $13.8 million for defective pricing and lost investment income as well as misstated MLR filings due to these errors.

Specifically, we found that the Plan:

- Included erroneous tax, pharmacy rebate, vision benefit, retention, and benefit change factor data in the premium rate developments;

- Included overstated premiums in the FEHBP MLR filings due to defective pricing findings as well as procedural errors with tax expense allocations;
- Paid claims to providers who did not have appropriate credentialing documentation; and
- Had insufficient internal controls surrounding the FEHBP premium rate development and MLR processes.

Geisinger Health Plan

Danville, Pennsylvania
Report No. 1C-GG-00-20-025
June 15, 2021

Geisinger (Plan) has participated in the FEHBP since 2007 and provides health benefits to FEHBP members in the Northeastern, Central, and South Central Pennsylvania areas. The audit covered contract years 2014 through 2016. During this period, the FEHBP paid the Plan approximately $20.9 million in premiums.

Errors and insufficient controls around FEHBP rating and MLR processes led to questioned costs of $553,257 and adjustments to the MLR penalties.

We determined that portions of the MLR and premium rate review calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016. This resulted in questioned costs totaling $553,257 for defective pricing and lost investment income, as well as MLR penalty adjustments due to these and other errors.

Specifically, we found that the Plan:

- Used inaccurate completion factors, erroneous benefit adjustment factors, and unallowable capitation costs in its rate developments;
- Did not remove FEHBP members who have primary Medicare coverage when calculating the Transitional Reinsurance Fee (TRF);
- Incorrectly reported medical and pharmacy claims expenses in its MLR;
- Allocated capitation expenses to the FEHBP MLR rather than reporting actual expenses;
- Did not calculate the Patient Centered Outcome Research Institute and TRF taxes reported on its FEHBP MLR in accordance with applicable criteria;
- Incorrectly processed and paid FEHBP medical claims; and
- Had insufficient internal controls surrounding the FEHBP premium rate development and MLR processes.

EXPERIENCE-RATED CARRIERS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan, indemnity benefit plan, and health plans operated or sponsored by Federal employee organizations, associations, or unions. Experience-rated HMOs also fall into this category. The universe of experience-rated plans currently consists of approximately 60 audit sites, some of which include multiple plans. When auditing these plans, our auditors generally focus on three key areas:

- Appropriateness of FEHBP contract charges and the recovery of applicable credits, including health benefit refunds and drug rebates;

- Effectiveness of carriers' claims processing, financial management, cost accounting, and cash management systems; and
- Adequacy of carriers' internal controls to ensure proper contract charges and benefit payments.

During the current reporting period, we issued two final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP. These two final audit reports contained recommendations for the return of over $7.9 million to the OPM-administered trust fund.

Blue Cross Blue Shield Service Benefit Plan Audits

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

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management of the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the BCBS Association, BCBS plans, and OPM. The BCBS Association also established an FEP Operations Center, the activities of which are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary between the BCBS Association and member plans, verifying subscriber eligibility, adjudicating member claims on behalf of BCBS plans, approving or disapproving the reimbursement of local plan payments for FEHBP claims (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining claims payment data.

The following is a summary of a recent BCBS audit that is representative of our work.

Health Care Service Corporation

Chicago, Illinois
Report Number 1A-10-17-20-013
April 19, 2021

Our multi-plan company audit of the FEHBP operations at the Health Care Service Corporation (HCSC) covered miscellaneous health benefit payments and credits (such as refunds and medical drug rebates) and administrative expense charges pertaining to the BlueCross BlueShield plans of Illinois, Montana, New Mexico, Oklahoma, and Texas. We also reviewed HCSC's cash management activities and practices related to FEHBP funds as well as HCSC's fraud and abuse program activities.

We questioned $87,142 in medical drug rebates, administrative expense overcharges, and lost investment income. We also identified a procedural finding for HCSC's cash receipt health benefit refunds. The BCBS Association and/or HCSC agreed with all of the questioned amounts as well as the procedural finding for HCSC's cash receipt refunds. As part of our review, we

verified that HCSC subsequently returned these questioned amounts to the FEHBP.

The audit disclosed no findings pertaining to HCSC's cash management activities and practices related to FEHBP funds or HCSC's fraud and abuse program activities.

Experience-Rated Comprehensive Medical Plans

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

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

Supplemental Audit of CareFirst BlueChoice, Inc.

Owings Mills, Maryland
Report Number 1D-2G-00-21-002
August 19, 2021

Our supplemental audit of the FEHBP operations at CareFirst BlueChoice, Inc. (Plan) covered an expanded review of voucher deduction refunds. We expanded our review of voucher deduction refunds because of significant concerns identified with these refunds during our recent audit of the Plan (Report No. 1D-2G-00-20-003, dated November 30, 2020). Voucher deductions occur when a plan reduces payments to participating providers or members for the purpose of recovering refunds related to previous claim overpayments.

The objective of our audit was to determine if the Plan properly returned voucher deduction refunds to the FEHBP in accordance with the terms of Contract CS 2879. We questioned $7,275,348 in voucher deduction refunds that had not been returned to the FEHBP as of November 30, 2020, and $560,314 in lost investment income calculated on these refund exceptions. For these refund exceptions, the Plan reduced payments to the providers via voucher deductions to recover FEHBP health benefit refunds related to previous claim overpayments, but then inadvertently had not returned these refunds to the FEHBP.

Information Systems Audits

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

Our audit universe encompasses all 46 OPM-owned information systems as well as the 73 information systems used by private sector entities that contract with OPM to process Federal data. We issued six IT system audit reports during the reporting period. Selected notable reports are summarized below.

Audit of the Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System

Washington, D.C.
Report Number 4A-CF-00-21-009
September 9, 2021

The Consolidated Business Information System (CBIS) is one of OPM's major IT systems. We completed a performance audit of CBIS to ensure that the system's security controls meet the standards established by Federal Information Security Management Act (FISMA), the National Institute of Standards and Technology (NIST), the Federal Information System Controls Audit Manual, and OPM's OCIO. Our audit of the IT security controls of CBIS determined that:

- A Security Assessment and Authorization (Authorization) was completed on April 5, 2021. The Authorization was granted for up to 90 days.
- The CBIS security categorization is consistent with Federal Information Processing Standards 199 and we agree with the "moderate" categorization.
- OPM has completed a Privacy Impact Assessment for CBIS.
- The CBIS System Security Plan was complete and follows the OCIO's template.
- The Office of the Chief Financial Officer did not perform a security assessment but has identified the deficiency.

- Continuous Monitoring for CBIS was conducted in accordance with OPM's quarterly schedule for fiscal year 2020.
- The CBIS contingency plan was completed in accordance with NIST Special Publication (SP) 800-34, Revision 1, and OCIO guidance.
- The CBIS Plan of Action and Milestones documentation is up to date and contains all identified weaknesses.
- We evaluated a subset of the system controls outlined in NIST SP 800-53, Revision 4. We determined most of the security controls tested appear to be in compliance; however, we did note several areas for improvement.

Audit of the General and Application Controls at Anthem, Inc.

Richmond, Virginia
Report Number 1A-10-18-21-007
September 13, 2021

Our IT audit focused on the claims processing applications used to adjudicate FEHBP claims for Anthem, Inc. (Anthem) members, as well as the various processes and IT systems used to support these applications. Our audit of the IT security controls of Anthem determined that:

- Anthem has adequate controls over security management.
- Anthem has adequate logical and physical access controls.
- Our vulnerability and compliance scan exercise identified technical weaknesses in Anthem's network environment.
- Anthem has adequate event monitoring and incident response controls.
- Anthem has adequate controls over its configuration management program.
- Anthem has adequate controls over contingency planning.
- Anthem has adequate controls over its application change control process.

Audit of the Information Technology Security Controls of the U.S. Office of Personnel Management's Benefits Financial Management System

Washington, D.C.
Report Number 4A-CF-00-21-010
September 14, 2021

The Benefits Financial Management System (BFMS) is one of OPM's major IT systems. We completed a performance audit of BFMS to ensure that the system's security controls meet the standards established by FISMA, NIST, the Federal Information System Controls Audit Manual, and OPM's OCIO. Our audit of the IT security controls of the BFMS determined that:

- An Authorization was completed in December 2020. The Authorization was granted for up to 18 months.
- The BFMS security categorization is consistent with Federal Information Processing Standards 199 and we agree with the "moderate" categorization.
- OPM does not have an approved Privacy Impact Assessment for the BFMS.
- The BFMS System Security Plan was complete and follows the OCIO's template.
- The Office of the Chief Financial Officer appropriately performed a security control assessment.
- Continuous Monitoring for the BFMS was conducted in accordance with the OPM's quarterly schedule for fiscal year 2020.

- The BFMS contingency plan test was not performed within the required annual cycle.
- The BFMS Plan of Action and Milestones documentation is up to date and contains all identified weaknesses.
- We evaluated a subset of the system controls outlined in NIST SP 800-53, Revision 4. We determined all of the security controls tested appear to be in compliance.

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. Our auditors are responsible for conducting comprehensive performance audits and special reviews of OPM programs, operations, and contractors, as well as conducting and overseeing certain statutorily required projects for improper payments and charge card reporting. Our staff also produces our Top Management Challenges report, oversees OPM's financial statement audit, and performs risk assessments of OPM programs. Our auditors also work with program offices to resolve and close internal audit recommendations.

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

OPM's Fiscal Year 2020 Improper Payments Reporting

Washington, D.C.
Report Number 4A-CF-00-21-008
May 17, 2021

The OIG annually audits OPM's reporting of improper payments to assess compliance with the Improper Payments Information Act, as amended by the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), as well as implementing Office of Management and Budget (OMB) guidance. On March 2, 2020, the Payment Integrity Information Act of 2019 (PIIA) (Public Law 116–117) repealed IPERA and other laws, but set forth similar improper payment reporting requirements, including an annual compliance report by Inspectors General. However, PIIA was not fully effective until fiscal year (FY) 2021. IPERA and PIIA requires agencies do the following:

- Publish improper payment information with the Agency Financial Report (AFR) or Performance and Accountability Report (PAR) for the most recent fiscal year and post that report and any accompanying materials required under OMB guidance on the agency website;
- If required, conduct a program-specific risk assessment for each applicable program or activity that conforms with section 3352(a) of PIIA;
- If required, publish improper payments estimates[10] for all programs and activities identified under section 3352(a) of PIIA in the accompanying materials to the AFR/PAR;
- Publish any programmatic corrective action plans prepared under section 3352(d) of PIIA that the agency may have in the accompanying materials to the AFR/PAR;
- Publish any improper payments reduction targets established under section 3352(d) of PIIA that the agency may have in the accompanying materials to the AFR/PAR for each applicable program or activity assessed to be at risk, and for which the agency has

[10] OPM's improper payment estimates are reported on paymentaccuracy.gov in Table 1, in the Out Year Projections column. The improper payment estimate is for future years.

demonstrated improvements and developed a plan to meet[11] the reduction targets; and

- Report an improper payment rate of less than 10 percent for each applicable program and activity for which an estimate was published under section 3352(c) of PIIA.

Our audit found that OPM complied with PIIA and IPERA's six requirements for FY 2020. PIIA and IPERIA include additional reporting requirements, such as utilizing the Do Not Pay portal and approval for both the improper payments rates and reduction targets. We determined that OPM is also in compliance with PIIA and IPERIA's additional reporting requirements. However, we identified four outstanding audit findings from prior years' audits.

OPM's Office of the Chief Information Officer's Revolving Fund Programs

Washington, D.C.
Report Number 4A-CI-00-20-034
September 9, 2021

Our auditors completed a performance audit of the OCIO's Human Resources Solutions' Information Technology Program Management Office (HRS IT PMO) and Electronic Official Personnel Folder (eOPF) office pricing and billing processes.

The OCIO's revolving fund programs—the eOPF office and HRS IT PMO—provide a continuing cycle of human resources services primarily to Federal agencies on a reimbursable basis. These revolving fund programs operate under OPM's Revolving Fund Authority, 5 United States Code (U.S.C.) § 1304 (e)(1)). This allows the programs to provide services at an agency's request. Both the eOPF office and HRS IT PMO have variations in the costing methodologies and pricing structures for the different services they provide to Federal agencies.

The objective of our audit was to determine if the eOPF office and the HRS IT PMO revolving fund programs' pricing and billings were accurate for FY 2020. We determined that controls over the pricing and billing processes should be strengthened. Specifically:

- While assessing the accuracy of the pricing tools used by the eOPF office and HRS IT PMO to develop their FY 2020 prices, we determined that their pricing methodologies were not fully supported, resulting in the eOPF office's customer agencies being overcharged $5,474,272 in FY 2020.

Pricing Methodologies were not fully supported resulting in a $5.4 million overcharge.

We selected 10 out of 30 FY 2020 HRS IT PMO service level agreements to determine if the customer agencies were accurately billed. We determined that HRS IT PMO inaccurately billed three customer agencies.

The OCIO concurred with all four of the recommendations in the final report.

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

OPM's Check Receipt Process in Trust Funds

Washington, D.C.
Report Number 4A-CF-00-20-035
September 30, 2021

Our auditors completed a performance audit of OPM's check receipt process in Trust Funds and teleworking and Personally Identifiable Information (PII) handling procedures that govern the process.

The OCFO's Trust Funds Management office (TFM) is responsible for administering accounting functions relating to check processing for the Federal Employees Health Benefits Fund, Federal Employees' Life Insurance Fund, and the Civil Service Retirement and Disability Fund (CSRDF). The TFM receives check remittances from current Federal employees, retirees and survivors, financial institutions, and Federal and non-Federal agencies daily. The checks, which come in the form of personal checks, cashier's checks, or money orders, are a method of collecting monies for the CSRDF, the Federal Employees Health Benefits Fund, the Retired Employees Health Benefits, and the Federal Employees' Group Life Insurance funds.

The objectives of our audit were to determine if TFM is: (1) timely processing the receipt of funds; (2) following policies and procedures related to the check receipt process; and (3) adhering to OPM and OCFO's internal teleworking and PII handling procedures.

We determined that TFM has approved telework agreements in place for all employees who work within the check receipt process. However, we identified three areas where the OCFO's internal controls over the check receipt process and PII handling procedures should be strengthened. Specifically:

- The TFM did not follow all procedures related to their check receipt process.
- TFM employees do not properly track documentation containing PII in accordance with their procedures.
- TFM has a timeliness metric (seven business days) established to process the receipt of funds. We were unable to determine if TFM processed the receipt of funds within seven business days from receipt due to incomplete and inaccurate data.

In response to the nine recommendations contained in our final report, the OCFO partially concurred with three recommendations and concurred with the remaining six.

Special Audits

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

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

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

The following summary highlights the results of an audit conducted on BCBS opioid claims during this reporting period.

Limited-Scope Audit of Blue Cross Blue Shield's Opioid Claims as Administered by CVS Caremark For the Service Benefit Plan

Cranberry Township, Pennsylvania, and
Jacksonville, Florida
Report Number 1H-01-00-20-015
May 26, 2021

We completed a limited scope audit of BCBS Service Benefit Plan's opioid claims as administered by the PBM, CVS Caremark (Caremark) for Contract Years 2017 through 2019. We conducted the audit to determine if BCBS and Caremark had proper controls in place to safely prescribe and dispense opioid drugs to FEHBP members. Our audit included a review of the BCBS' opioid utilization and trends, fraud and abuse program, and opioid claims processing to determine if there were sufficient policies and procedures in place to reduce opioid misuse.

We determined that BCBS' opioid drug claims decreased from 2017 through 2019 while membership remained steady. Although industry improvements were made over the years to help combat the opioid epidemic, our audit testing found that Caremark needs to strengthen its controls to ensure that only allowable opioids are safely prescribed and dispensed to BCBS Federal members to help reduce the risk of opioid misuse.

Our audit results are summarized as follows:

- Caremark's claim system lacked edits to limit excessive quantities of opioids from being paid for prescriptions that were for less than a 90-day supply, thereby failing to comply with CDC guidelines and BCBS's policies; and
- Caremark paid claims that exceeded a 7-day supply for opioid naive members (members with no prior opioid prescriptions within 180 days), and paid claims that exceeded 50

morphine milligram equivalent (MME) per day for immediate-release opioid and opioid combination drugs, without obtaining the prior approvals required by BCBS's policies. This occurred because the PBM does not have the ability to calculate the daily MME on opioid prescriptions that are less than a 90-day supply (which is for most opioid prescriptions).

Caremark lacked sufficient system edits to limit the quantity of opioids in accordance with the CDC guidelines and BCBS policies.

ENFORCEMENT ACTIVITIES

Investigative Activities

The Office of Investigations' mission is to protect Federal employees, annuitants, and their eligible family members from fraud, waste, abuse, and mismanagement in OPM programs. We pursue this mission by conducting criminal, civil, and administrative investigations related to OPM programs and operations. OPM annually disburses more than $140 billion in benefits through the Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), FEHBP, and FEGLI. These programs are paid from OPM-administered trust funds that collectively hold over $1 trillion in assets. More than 8.5 million current and retired Federal civilian employees and eligible family members receive benefits through these programs. Our investigations safeguard OPM's financial and program integrity and protect those who rely on OPM programs. The Office of Investigations prioritizes investigations into allegations of harm against those reliant on OPM programs, the substantial loss of taxpayer dollars, or agency program weaknesses that allow fraud, waste, and abuse.

In this Semiannual Report to Congress, we present a representative summary of our investigative successes in protecting OPM programs and beneficiaries from fraud, waste, abuse, or mismanagement. We also discuss some operational challenges we face.

Our investigative operations continue to adapt to complexities brought by the COVID-19 pandemic. We have moved towards resuming normal investigative activities as employee safety permits. However, investigative results during this semiannual reporting period reflect that the pandemic reduced criminal investigator travel, limited our ability to work with partners at the Department of Justice (DOJ), and otherwise constrained investigative activities throughout 2020 and into 2021. We anticipate subsequent semiannual reports will see the OIG return to its previous levels of investigative output.

An indictment is merely an allegation. Defendants referenced in these case summaries are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

FEHBP Health Care Fraud Investigations

On average, more than two-thirds of the cases we investigate involve health care fraud affecting the FEHBP. Our criminal investigators routinely encounter complex, sophisticated health care fraud schemes.

Fraud schemes do not only financially harm the FEHBP and Federal Government; in many cases, our investigations find that suspects have harmed patients. The ongoing health care crises affecting the United States—both the COVID-19 pandemic and the opioid/substance abuse crisis—make our work even more important as

we provide oversight of the FEHBP and protect its beneficiaries.

In this semiannual report, we focus our discussion of health care fraud affecting the FEHBP on:

- The current status of our work involving and affected by the COVID-19 pandemic;
- Our continued efforts to combat the opioid and substance abuse crisis; and
- Summaries of investigations involving traditional health care fraud schemes (such as medical providers billing for impossible days, and violations of the False Claims Act) that commonly affect the FEHBP.

Special Topic: Ongoing COVID-19 Investigations and Efforts in the FEHBP

We continue to investigate allegations of fraud, waste, and abuse within the FEHBP that involve the COVID-19 pandemic.

However, we do not report the results of any COVID-19 investigations during this semiannual reporting period. This is expected- health care fraud investigations are lengthy and complex. Cases often take at least a year to resolve, even without a pandemic's impediments. The Office of Investigations experienced complications from staff's reduced ability to travel and conduct investigative activities (such as in-person interviews) during some periods of the pandemic, and other factors. The residual effect of these delays will continue to impact investigations for some time.

Many of the case referrals related to the COVID-19 pandemic from our law enforcement partners, the OIG Hotline, and the FEHBP health insurance carriers allege complex schemes of improper billing, upcoding, or duplicate billing for testing services. COVID-19 schemes are also potentially latching on to other common health care frauds such as unbundling and panel testing schemes that involve overbilling or duplicative billing.

Telemedicine usage also surged during the pandemic. While beneficial for health care accessibility and maintaining care during the pandemic, bad actors can abuse telemedicine as part of fraud schemes.

We continue to prioritize investigating fraud, waste, and abuse affecting the FEHBP related to COVID-19, and we will report relevant COVID-19–related investigations in the future.

Special Topic: The Opioid and Substance Abuse Crisis in the FEHBP

The opioid and substance abuse crisis continues throughout the United States, compounded by the COVID-19 pandemic. While many deaths are due to illicitly manufactured synthetic opioids (like fentanyl), prescription opioid abuse remains a concern.

The OIG continues to vigorously investigate opioid-related fraud, waste, and abuse affecting the FEHBP. For example, we have previously investigated cases involving:

- Drug manufacturers or pharmaceutical companies that illegally encourage the proliferation of drugs of abuse and attempt to exploit the health care system for financial gain, often at the risk of patient harm;
- Unethical doctors and medical providers who prescribe opioids or other potentially abused drugs without establishing medical

relationships, determining medical necessity, or following appropriate prescribing guidelines;

- FEHBP members who shop doctors to maintain a supply for their addiction or sell medications that supply those suffering from addiction; and
- Disreputable sober homes and recovery centers that bill for unnecessary and inflated drug testing or exploit patients seeking treatment and allow drug abuse, relapse, and patient harm.

This Semiannual Report does not feature a summary of any specific opioid-related cases because none of our ongoing cases are at publicly reportable stages of investigation. Other cases were summarized in previous semiannual reports to Congress. However, we include this special topics brief to emphasize that fraud, waste, and abuse related to the opioid crisis remains a concern, and our efforts to protect FEHBP enrollees from opioid-related fraud, waste, or abuse is an ongoing priority. This includes ongoing work by our Investigative Support Operations group, which helps generate case leads and other oversight information based on its opioid-related data analysis and research.

Summaries of Select FEHBP Health Care Investigations

Providing Oversight of FEHBP Health Insurance Carriers

The FEHBP is a network of private health insurers that contract with OPM to provide health insurance services. The OIG has previously noted in its Top Management Challenges reports that there are vulnerabilities (including in FEHBP health insurance carrier fraud, waste, and abuse prevention programs) related to the structure of the program.

Providing oversight of FEHBP carriers is an essential duty of the OPM OIG – including the Office of Investigations – when criminal, civil, or administrative allegations arise.

In our previous Semiannual Report to Congress (October 2020 through March 2021), we reported a civil settlement involving an FEHBP health insurance carrier. This settlement was based on a whistleblower's allegations that a provider group improperly billed for telehealth services. The FEHBP health insurance carrier knew the claims were fraudulent and paid them anyway. Based on our investigation, the FEHBP carrier paid a settlement and ultimately reorganized its special investigations unit (SIU), the internal group that investigates health care fraud committed against the contracted carrier.

During this semiannual reporting period, we report another case—a criminal investigation—involving oversight of an FEHBP health insurance carrier.

FEHBP Health Insurance Carrier Employee Allegedly Conspires in Cosmetic Services Scheme

In January 2015, a law enforcement partner informed us of allegations that medical spas were providing cosmetic services such as hair removal, massages, microdermabrasion, and BOTOX treatments but billing the services as medical procedures. Furthermore, the scheme involved inducing patients to visit the spas for free cosmetic services not covered by insurance. The spas captured insurance information and later billed insurance companies, including FEHPB carriers, for services normally covered but that were never provided.

Our investigation uncovered reasons to suspect that a senior SIU investigator at a health insurance carrier

traded cash payments for information that helped the medical spas avoid fraud detection safeguards.

The SIU investigator allegedly provided certain billing codes that the SIU investigator knew would not be detected as fraud and worked to help the medical spa's owners avoid fraud investigations at other insurance carriers. The SIU investigator's illegal assistance allegedly went so far as to outright close SIU investigations into the clinics.

After the alleged involvement of the SIU investigator was uncovered, they were removed from the insurance carrier's SIU. The FEHBP health insurance carrier cooperated with our investigation.

The FEHBP had paid the medical spas $201,738. In 2018, six individuals were indicted in the U.S. District Court for the Central District of California on various charges, including health care fraud and conspiracy to commit health care fraud.

On April 12, 2021, one individual who previously pled guilty to one count of conspiracy to commit health care fraud was sentenced to 18 months in prison and ordered to pay $7.9 million in restitution, of which $185,611 will be returned to the FEHBP. Other individuals implicated in the fraud schemes, including the former SIU investigator, are still under indictment and awaiting trial.

The OPM OIG will continue to provide oversight of the FEHBP's contracted carriers to stop fraud, waste, or abuse that involves FEHBP carriers or their employees. Our diligence in these efforts is essential to maintaining the integrity of the FEHBP.

Chiropractor Bills for 2,000 Hours in 1 Day in Fraud Scheme

Beginning in June 2018, we coordinated with a Federal law enforcement partner to investigate allegations that a Pennsylvania chiropractor submitted numerous false claims for services that were never provided. Once, the chiropractor billed for 2,000 hours of services in a single day.

The FEHBP paid the chiropractor $74,110 related to the fraud scheme.

In January 2020, the chiropractor was charged in the U.S. District Court for the Eastern District of Pennsylvania with committing health care fraud. In July 2020, he pled guilty. On June 20, 2021, the chiropractor was sentenced to 5 years of probation, including 6 months of house arrest. The court also ordered the chiropractor to pay $99,037 in restitution, of which $3,082 will be returned to OPM.

Orlando Cardiologist Settles to Resolve Allegations of Performing Unnecessary Medical Procedures

A cardiologist based in Orlando, Florida, entered into a settlement with the U.S. Government to resolve allegations he violated the False Claims Act by performing medically unnecessary procedures, including misrepresenting patient records to justify the procedures. The cardiologist will pay $6.75 million to the Government. OPM will receive $250,000 from the settlement.

The FEHBP's exposure over the course of the scheme was $721,840.

> The Orlando cardiologist will pay the Government $6.75 million. OPM will receive $250,000. More information on this case is available from DOJ.

This case involved potential patient harm, a priority allegation for our Office of Investigations. The vein stent and ablative procedures that

the cardiologist performed were medically unnecessary. Changing patient records and overstating or falsely documenting patient symptoms to justify invasive, unneeded procedures violates the trust between a doctor and patient, as well as the oath to do no harm.

We vigorously investigate cases that potentially involve medical providers harming FEHBP members.

Fraud, Waste, and Abuse Investigations Involving OPM Retirement Programs

Fraud, waste, and abuse that affects OPM Retirement Programs (most commonly the FERS and CSRS programs) is costly: OPM reported it made $299 million in retirement-related improper payments in fiscal year 2020. These improper payments waste taxpayer dollars and can harm annuitants reliant on OPM Retirement Programs. We protect the OPM Retirement Programs and annuitants through our investigations of fraud, waste, and abuse. Many of the retirement cases we investigate can involve years of improper payments, such as the case outlined below: "Survivor Annuitant Pleads Guilty to Defrauding Government for 19 Years."

As part of its oversight, the Office of Investigations uses proactive record searches to find potential improper payments in the OPM Retirement Programs. This proactive work generates investigative leads that can result in administrative, criminal, or civil cases. We also submit records and investigative information to OPM so the agency can stop payments and pursue administrative actions such as Treasury reclamation actions.

Beyond pursuing punitive remedies to improper payments, our work sometimes finds opportunities for annuitants and survivor annuitants to receive payments duly owed by OPM. In this semiannual reporting period, our proactive work discovered several annuities due to annuitants or survivor annuitants. This included three annuities of approximately or more than $50,000. One case involved $87,578 in owed annuity money that OPM was able to pay to a living retired annuitant.

Survivor Annuitant Pleads Guilty to Defrauding the Government for 19 Years

An OPM survivor annuitant pled guilty on September 7, 2021, in Maryland State Court, Prince George's County District, to one count of theft scheme ($25,000 to under $100,000) for stealing $34,569 by collecting a survivor annuity he was not entitled to collect. The subject in this case illegally collected the survivor annuity over the course of 19 years.

In August 2000, an OPM annuitant died. Her husband was entitled to survivor annuity benefits until he remarried. A survivor annuitant who remarries prior to age 55 is ineligible to continue receiving an annuity unless they were married to the Federal annuitant for 30 years prior to the annuitant's death.

In this case, the survivor annuitant remarried about a year later, in July 2001. From then on, he was ineligible to continue receiving survivor annuity payments. During the 19 years of illegally receiving the annuity, he signed and sent at least one form attesting to OPM that he had never remarried. We learned of the fraud after receiving anonymous information via our OPM OIG Hotline.

According to the terms of the plea agreement, the former survivor annuitant received a 5-year suspended sentence and 5 years of supervised

probation, as well as being ordered by the court to pay $34,569 dollars in restitution.

Representative Payee Steals $35,000 After Annuitant's Death

On April 27, 2021, the Representative Payee of an OPM survivor annuitant was sentenced by the U.S. District Court for the Southern District of Ohio to 5 years of probation after pleading guilty to two counts of theft of public money. The Representative Payee was also ordered to pay $35,401 as restitution for the stolen funds.

In 2012, the Representative Payee began to receive payments from OPM to manage the funds for the OPM survivor annuitant. The survivor annuitant died several months later. Instead of notifying OPM as legally required, the Representative Payee continued to collect OPM annuity payments for almost 7 years. In all, they illegally took $35,401 in post-death annuity payments. OPM had also paid health benefits premiums totaling $52,950 until the improper payments stopped. Those premiums were recovered through Treasury's reclamation process.

Fraud by Representative Payees abuses a system based on the Government's ability to trust Representative Payees to fulfill their duties faithfully and in such a way that protects both the welfare of the annuitant and the interests of the Government. We investigate cases of fraud, waste, and abuse that involve Representative Payees and OPM programs to protect beneficiaries and the OPM Retirement Programs.

Update on NBIB Investigations

On October 1, 2019, the Federal Government's background investigative function transferred from OPM to the Department of Defense (DoD), changing from the National Background Investigations Bureau (NBIB) to the Defense Counterintelligence and Security Agency (DCSA). Our Office of Investigations previously provided investigative services for allegations of fraud, waste, or abuse affecting NBIB background investigations. After the migration of DCSA, we closed almost all of our investigations, allowing DoD to pursue those cases at its discretion. We kept open only cases that were significantly far along in the judicial process.

In this semiannual reporting period, we provide the following update to one NBIB case that our criminal investigators continued to participate in:

Contract Background Investigator Sentenced for Falsifying Reports of Investigation

On July 19, 2021, a former contract background investigator was sentenced to 24 months of probation and 200 hours of community service, as well as ordered by the court to pay $86,562 in restitution and a fine of $4,000. The former contract background investigator had pled guilty in March 2021 in the U.S. District Court for the District of Columbia to one count of making a false statement. This case was predicated on a referral we received from the then NBIB's Integrity Assurance group that alleged the former contract background investigator submitted false and inaccurate reports of investigation. Our investigation found the former contract background investigator submitted 26 falsified reports of investigation. These falsified reports and the associated recovery effort cost OPM $105,186.

Agency Oversight and Integrity Investigations

As a fundamental part of the OPM OIG's oversight mission, our Office of Investigations investigates fraud, waste, abuse, or mismanagement by OPM employees. We are also required by the Inspector

General Act of 1978, as amended, to report all substantiated allegations of misconduct by senior OPM officials.

For this semiannual period, we have no investigations to report regarding the substantiated misconduct of a senior OPM official.

Hurricane Ida Recovery Assistance: Office of Investigations Special Agents Volunteer with Emergency Support Function #13

On August 29, 2021, Hurricane Ida violently swept northward over the Gulf Coast, endangering lives and damaging homes and businesses. The hurricane's aftermath was also dangerous. In some places, winds and flooding knocked out water and electric utilities. People faced a sweltering, deadly heatwave in the days that followed.

One of the hardest hit areas was Kenner, Louisiana.

OPM OIG Special Agents who volunteer with the Federal Emergency Management Agency's (FEMA's) Emergency Support Function #13 (ESF #13) deployed to Ochsner Medical Center in Kenner to support a FEMA Disaster Medical Assistance Team (DMAT). Two OPM OIG special agents, as well as special agents from the Coast Guard Investigative Service, provided protection, security, and armed transportation for the DMAT.

> Emergency Support Function #13 includes Federal law enforcement agents who provide Federal public safety and security assistance to local, State, Tribal, Territorial, and Federal organizations overwhelmed by the results of an actual or anticipated natural/manmade disaster or an act of terrorism.

Hurricane Ida created a desperate situation for many people in Kenner. Heat exhaustion, dehydration, and accidental injuries related to cleanup efforts required urgent medical treatment. With a high number of COVID-19 cases and wind and flood damage to the Ochsner Medical Center, the DMAT provided crucial additional medical personnel and equipment to care for patients. The presence of our special agents in ESF #13 allowed the DMAT to focus on providing medical care while knowing that they worked in a secure and safe location. ESF #13 provided force protection for the DMAT as medical personnel administered care at the emergency disaster triage location, emergency room, and intensive care units.

Our special agents who volunteer for ESF #13 stay in a ready state. They are able to deploy within 24 hours when needed. The OIG commends its special agents who volunteer for this duty and thanks them for their service to the American public in times of need.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (5 U.S.C. § 8902a), we suspend or debar health care providers whose actions demonstrate they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were 37,331 active suspensions and debarments of health care providers from participating in the FEHBP.

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

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

During the reporting period, our office issued 280 administrative sanctions, including both suspensions and debarments, of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we responded to 1,694 sanctions-related inquiries.

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

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

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

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

Missouri Hospital CEO Debarred for Health Care Fraud

In June 2021, we debarred a Missouri businessman who was the Chief Executive Officer (CEO) of a hospital based on his conviction in the U.S. District Court for the Middle District of Florida, Jacksonville Division, for Conspiracy to Commit Health Care Fraud in violation of 18 U.S.C. § 1849. The individual was indicted in Missouri and the case was transferred to Florida, where he pled guilty to the charges.

The CEO and his coconspirators carried out a pass-through billing scheme in which the hospital was used to submit fraudulent claims for toxicology and blood testing. As a result, multiple insurance companies and the Missouri Medicaid program paid over $100 million in fraudulent claims. The CEO and others, including a laboratory owner, arranged for urine drug tests and blood tests to be performed at diagnostic testing laboratories near Missouri on individuals who were not patients of the hospital and who had no connection to the hospital. To obtain samples for testing, the CEO and coconspirators entered arrangements with marketers who solicited samples from substance abuse treatment centers, sober living homes, physicians' offices, and other sources throughout the United States in exchange for a portion of the insurance reimbursements. Many of the tests conducted were medically unnecessary. The conspirators billed the tests to private insurers and to the Missouri Medicaid program using the hospital's billing credentials. This was done to take advantage of the hospital's favorable reimbursement rates under its in-network contracts with insurers. The CEO and his coconspirators failed to reveal that most of the testing had not taken place at the facility listed. The CEO admitted that during a 15-month period, he and his coconspirators were paid $114 million by the Missouri Medicaid Program, FEHBP, and private health care insurers. The US District Court's Plea Agreement included the forfeiture of assets totaling at least $5,100,000. The CEO agreed to forfeit to the United States any assets and all property, or portions thereof, that he personally obtained from his participation in the health care fraud conspiracy scheme.

Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. We debarred the provider for 10 years from participating in the FEHBP based on the level of his culpability and the seriousness of his underlying conduct.

Florida Business Owner Debarred for Telemedicine Scheme

On April 20, 2021, we debarred a business owner convicted of health care related fraud. The business owner worked with doctors, pharmacists, and marketers to fraudulently bill insurance companies for compound cream and metabolic pill prescriptions based on services never rendered. In addition, he rewarded coconspirators with illegal kickbacks. Losses to all health insurance programs exceeded $50 million. The impact to the FEHBP was $4,227,103.

The business owner resided in St. Augustine, Florida, where he falsely represented that he ran a telemedicine practice and related business out of his residence. The business was used to identify the names of health insurance beneficiaries whose compounded medication prescriptions would be sought for the purpose of generating commissions for the benefit of the owner and others in the health care scheme.

From approximately April 2015 through July 2016, the owner of the telemedicine business and others knowingly combined, conspired, and agreed to commit health care fraud. The conspiracy involved the business owner contracting with pharmacies so that he could refer compound medication prescriptions in exchange for commissions of approximately 40 percent or more of net reimbursements paid by a Federal health insurance program.

The business owner entered into agreements with physicians wherein he would agree to pay them to review patient information and write compound medication prescriptions that he and others would, in turn, refer to pharmacies in exchange for referral fees. The business owner knowingly and willfully falsely represented to each physician that he operated a telemedicine business. He also recruited individuals with no health care experience to solicit Federal health insurance beneficiaries to seek compound medication prescriptions. He, along with these individuals, would falsely represent to the beneficiaries that the medications would be available at no cost to them.

On July 17, 2018, in the U.S. District Court for the Central District of California, the individual pled guilty to one count of Conspiracy to Commit Health Care Fraud. Sentencing has been continued to November 22, 2021.

Mitigating and aggravating factors were considered in determining the length of debarment. While OPM debarments typically run a minimum of three years, OPM authority allows for a longer period based on aggravating factors. The aggravating factors above warranted a five-year debarment period for the business owner.

This case was identified by our Administrative Sanctions Program Group.

Five Providers Debarred and Three Suspended for Goody Bag Scheme

Our office debarred a licensed physician and suspended three of his affiliates who were indicted in September 2019 by the U.S. District Court for the Eastern District of Pennsylvania for health care fraud, conspiracy to distribute controlled substances, and aiding and abetting. Additionally, we debarred four of the dispensaries owned by the licensed physician.

From approximately November 2015 to approximately July 2019, the licensed physician, two foreign-trained physicians unlicensed in the United States, and the provider's employee, together with others (collectively hereafter referred to as the parties), knowingly and willfully executed and attempted to execute, and aided and abetted, a scheme and artifice to defraud health care benefit programs. The parties submitted, or caused to be submitted, fraudulent claims to health care benefits programs for medically unnecessary prescription medications that were dispensed by the dispensaries. The parties, through the licensed physician's dispensaries, billed health care benefit programs for bags of medication (goody bags) and were paid over $4 million. The parties billed the FEHBP approximately $305,906 and were paid $50,690. The parties also prescribed $269,898 worth of medication for which the FEHBP paid $253,047.

During the scheme, the parties played various roles:

- The licensed physician prescribed Schedule II controlled substances, including oxycodone, outside the usual course of professional practice and without legitimate medical purpose. He prepared pre-signed blank prescription pads for the unlicensed individuals so that they could issue prescriptions for Schedule II controlled substances to patients.
- The parties knowingly and intentionally conspired to distribute and dispense, without legitimate medical purpose and outside the usual course of professional practice, a mixture and substance containing a detectable amount of oxycodone, a Schedule II controlled substance. Specifically, the licensed physician

and coconspirators provided patients with bags of medication (the goody bags) containing numerous prescription medications that were dispensed by the dispensaries based on what a particular patient's insurance covered, not based on the patient's medical needs. The goody bags contained a variety of medically unnecessary medications, including analgesics, sedatives, muscle relaxants, and anti-inflammatory drugs without dosage and usage directions for the medications. Patients were coerced to accept these goody bags, which were not eligible for reimbursement, to receive their prescriptions for pain medications, including Schedule II controlled substances.

- The parties executed a scheme to defraud health care benefit programs and to obtain or cause to be obtained, money under the custody and control of those programs in connection with the delivery of, and payment for, health care benefits and services. For instance, copayments from the patients were not collected, but the patients were required to falsely sign that they paid one.

In April 2021, we debarred the licensed physician based on the indefinite suspension of his medical license by the Commonwealth of Pennsylvania, State Board of Medicine, pending the resolution of his criminal case. We also debarred the four dispensaries owned by the debarred provider used in the conspiracy.

In March 2021, we suspended the two foreign physicians who were unlicensed in the U.S., and the licensed physician's employee based on their 2019 indictments. Their criminal cases remain pending.

This case was referred to us by the OPM OIG's Office of Investigations.

Six Health Care Entities Debarred Based on Ownership by Debarred Providers

Two debarred providers continued to submit reimbursement claims for services rendered during their debarment periods. As a result, in April 2021, we debarred two chiropractic offices and the manager of the chiropractic offices. In August 2021, we debarred two medical offices and one home health care facility.

The two providers were debarred in 2002 and 2015, based on their exclusions by the Department of Health and Human Services (HHS). Both providers' OPM debarment and HHS exclusion remain in effect.

The National Association of Letter Carriers Health Plan (NALC) notified our office that it received claims for services rendered by the two debarred providers during their debarment periods. As a result, we issued a notice to each provider to remind them that OPM's debarment prohibits them from participating in FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. Also, we informed the providers that their actions were in violation of their debarment terms, and should they continue to submit or cause the submission of FEHBP claims during their debarment period, these actions could be deemed violations of the Federal false claims statutes and potentially result in prosecution by a U.S. Attorney's Office. In addition, the providers were informed that such claims may be a basis for OPM to deny or delay future reinstatement into the FEHBP.

5 U.S.C. § 8902a(c)(2)(d), provides the authority to debar an entity that is owned or controlled by a sanctioned provider. In addition, under OPM's statutory authority (5 U.S.C. § 8902a(c)(3)), a debarment shall be applied to an individual that owns or controls a sanctioned entity.

The providers' violations prompted our Administrative Sanctions Program staff to investigate the entities with which the two debarred providers were affiliated. The investigation identified two chiropractic offices owned or controlled by one of the debarred providers, which resulted in the April 2021 debarments of the entities. These debarments will coincide with the debarment terms of the provider who holds ownership or control. The same investigation revealed that the provider's spouse was a manager for the debarred offices. Therefore, we debarred the spouse based on his controlling interest in the debarred entities. The spouse's debarment will coincide with the debarment terms of the entities.

Our staff's investigation into the entities affiliated with the second provider identified two medical offices and one home health care facility owned or controlled by the debarred provider, which resulted in the August 2021 debarments of the entities. The entities were debarred based on the ownership or control interest held by the debarred provider and will run for a period that coincides with the provider's debarment.

These cases were identified by the Administrative Sanctions Program Group.

Kentucky Physician and His Two Clinics Debarred for Health Care Fraud

In June 2021, we debarred a Kentucky physician after his license was suspended for health care fraud. The Kentucky Board of Medical Examiners (Board) cited Kentucky Revised Statute 311.592(1), which provides that the Board may issue an emergency order suspending or restricting a physician's license if the panel has determined the physician constitutes a danger to the health, welfare, and safety of their patients or the general public. The Board's decision to suspend the physicians license was based on the indictment of the physician in the U.S. District Court for the Western District of Kentucky at Louisville on the following:

- Count 1, Unlawful Distribution and Dispensing of Controlled Substances Conspiracy, in violation of 21 U.S.C. §§ 841(a)(1), 841(b)(1)(C), 841(b)(1)(E)(i), and 846.
- Counts 2–5, Unlawful Distribution and Dispensing of Controlled Substances–Schedule II, in violation of 21 U.S.C. §§ 841(a)(1) and 841(b)(1) (C).
- Counts 6–7, Unlawful Distribution and Dispensing of Controlled Substances–Hydrocodone, in violation of 21 U.S.C. §§ 841(a)(1) and 841(b)(1)(E)(i).
- Count 8, Health Care Fraud Conspiracy, in violation of 18 U.S.C. § 1349.

Federal regulations state that FEHBP Debarring Official may debar, from participating in the FEHBP, providers of health care services 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.

Also, OPM may debar an entity in which a debarred provider has ownership or a controlling

interest. Therefore, our office debarred two clinics owned by the physician.

The FEHBP Debarring Official's debarment of the physician will remain in effect for an indefinite period pending the resolution of his medical license and outcome of his trial. The debarment of the two clinics will coincide with the physicians' term of debarment. This case was referred to us by Blue Cross Blue Shield.

EVALUATION ACTIVITIES

The Office of Evaluations provides an alternative method for conducting independent, credible, and thorough reviews of OPM's programs and operations to prevent waste, fraud, and abuse. The Office of Evaluations quickly analyzes OPM concerns or issues that need immediate attention by using a variety of review methods and evaluation techniques. The work by the Office of Evaluations 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. Office of Evaluations reports provide OPM management with findings and recommendations that will assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

Evaluation of OPM's Response to the COVID-19 Pandemic

Washington, D.C.
Report Number 4K-FS-00-20-042
May 6, 2021

Our analysts completed an evaluation of OPM's response to the COVID-19 pandemic. In May 2020, OPM issued a Returning to OPM Facilities Preparedness Guide (Guide) to assist managers with the transition to reopen its offices during the COVID-19 pandemic. The Guide did not specifically identify when employees would return to the office but provided a framework to support OPM supervisors with guidelines and planning considerations for evaluating the needs of employees as OPM returns from a maximum telework operating status.

During our evaluation, we determined that:

- Improvements were needed for processing COVID-19 incidents;
- OPM management did not require workers to wear face coverings; and
- OPM needed to implement additional signage for entering, social distancing, and routine cleaning and disinfecting at the Theodore Roosevelt Federal Building.

We made six recommendations aimed to improve OPM's plan for returning employees to its offices and practices to reduce the risk of employees' exposure to COVID-19. OPM management has taken corrective actions to address our recommendations, and we consider all six recommendations closed.

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Investigative Actions and Recoveries:

Indictments and Criminal Informations	10
Arrests	7
Convictions	14
Criminal Complaints/Pre-Trial Diversion	0
Subjects Presented for Prosecution	30
Federal Venue	30
Criminal	18
Civil	12
State Venue	0
Local Venue	0
Expected Recovery Amount to OPM Programs	$2,435,089
Civil Judgments and Settlements	$595,823
Criminal Fines, Penalties, Assessments, and Forfeitures	$1,021,021
Administrative Recoveries	$2,626,693
Expected Recovery Amount for All Programs and Victims[12]	$75,228,300

Investigative Administrative Actions:

FY 2021 Investigative Reports Issued[13]	490
Issued between October 1, 2020 – March 31, 2021	341
Issued between April 1, 2021 – September 30, 2021	149
Whistleblower Retaliation Allegations Substantiated	0

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

[13] The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports.

Cases Referred for FEHBP Suspension and Debarment 1

Personnel Suspensions, Terminations, or Resignations 0

Referral to the OIG's Office of Audits 0

Referral to an OPM Program Office 80

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued 280

FEHBP Provider Debarment and Suspension Inquiries 1,694

FEHBP Debarments and Suspensions in Effect at the End of Reporting Period 37,331

Table of Enforcement Activities

	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened[14]	**1,093**	**156**	**0**	**9**	**1,258**
Investigations[15]	17	12	0	1	30
Preliminary Investigations[16]	46	23	0	3	72
FEHBP Carrier Notifications/Program Office	873	39	0	1	913
Complaints – All Other Sources/Proactive[17]	157	82	0	4	243
Cases Closed	982	116	2	4	**1,104**
Investigations	23	10	2	0	35
Preliminary Investigations	28	6	0	1	35
FEHBP Carrier Notifications/Program Office	810	13	0	0	823
Complaints – All Other Sources/Proactive	121	87	0	3	211
Cases In-Progress[18]	358	94	1	10	**463**
Investigations	121	37	1	4	163
Preliminary Investigations	77	33	0	6	116
FEHBP Carrier Notifications/Program Office	119	9	0	0	128
Complaints – All Other Sources/Proactive	41	15	0	0	56

[14] The total number of cases opened may include cases converted from complaints or carrier notifications to preliminary investigations or from preliminary investigations to investigations, or both. Therefore, the total number of cases opened may include a small number of cases repetitively counted across multiple categories.

[15] This includes preliminary investigations from this reporting period and previous reporting periods converted to investigations during this reporting period.

[16] This includes complaints or carrier notifications from this reporting period and previous reporting periods converted to preliminary investigations during this reporting period.

[17] Complaints excludes allegations received via the OPM OIG Hotline, which are reported separately in this report.

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

OIG HOTLINE CASE ACTIVITIES

OIG HOTLINE CASES RECEIVED 1,287

Sources of OIG Hotline Cases Received

Website 780

Telephone 328

Letter 60

Email 119

In-Person 0

By OPM Program Office

Healthcare and Insurance 226

Customer Service 66

Healthcare Fraud, Waste, and Abuse Complaint 147

Other Healthcare and Insurance Issues 13

Retirement Services 235

Customer Service 154

Retirement Services Program Fraud, Waste, and Abuse 61

Other Retirement Services Issues 20

Other OPM Program Offices/Internal Matters 72

Customer Service 16

Other OPM Program/Internal Issues 51

Employee or Contractor Misconduct 5

External Agency Issues (not OPM-related) 754

OIG HOTLINE CASES REVIEWED AND CLOSED[19] 1,426

Outcome of OIG Hotline Cases Closed

Referred to External Agencies 224

Referred to OPM Program Office 382

Retirement Services 262

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

OIG HOTLINE CASES PENDING[20] 41

By OPM Program Office

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

APPENDICES

APPENDIX I-A

FINAL REPORTS ISSUED WITH QUESTIONED COSTS FOR INSURANCE PROGRAMS

April 1, 2021 to September 30, 2021

	Subject	Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	5	$3,049,570
B.	Reports issued during the reporting period with findings	4	$22,263,056
	Subtotals (A+B)	9	$25,312,626
C.	Reports for which a management decision was made during the reporting period:	6	$10,144,389
	1. Net disallowed costs	N/A	$9,250,678
	a. Disallowed costs during the reporting period	N/A	$9,941,394[1]
	b. Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$690,716[2]
	2. Net allowed costs	N/A	$893,711
	a. Allowed costs during the reporting period	N/A	$202,995[3]
	b. Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$690,716[2]
D.	Reports for which no management decision has been made by the end of the reporting period	3	$15,168,237
E.	Reports for which no management decision has been made within 6 months of issuance	2	**$1,381,242**

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

[2] Represents questioned costs which were determined by management to be allowable charges per the contract, subsequent to an initial management decision to disallow and establish a receivable. The receivable may have been set up in this period or previous reporting periods.

[3] Represents questioned costs (overpayments) which management allowed and for which no receivable was established. It also includes the allowance of underpayments to be returned to the carrier.

APPENDIX I-B

FINAL REPORTS ISSUED WITH QUESTIONED COSTS FOR ALL OTHER AUDIT ENTITIES

April 1, 2021 to September 30, 2021

	Subject	Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	0	$0
B.	Reports issued during the reporting period with findings	0	$0
	Subtotals (A+B)	0	$0
C.	Reports for which a management decision was made during the reporting period:	0	$0
	1. Net disallowed costs	N/A	$0
	2. Net allowed costs	N/A	$0
D.	Reports for which no management decision has been made by the end of the reporting period	0	$0
E.	Reports for which no management decision has been made within six months of issuance	0	$0

APPENDIX II

RESOLUTION OF QUESTIONED COSTS IN FINAL REPORTS FOR INSURANCE PROGRAMS

April 1, 2021 to September 30, 2021

	Subject	Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$3,049,570
B.	Value of new audit recommendations issued during the reporting period	$22,263,056
	Subtotals (A+B)	$25,312,626
C.	Amounts recovered during the reporting period	$9,250,678
D.	Amounts allowed during the reporting period	$893,711
E.	Other adjustments	$0
	Subtotals (C+D+E)	$10,144,389
F.	Value of open recommendations at the end of the reporting period	$15,168,237

APPENDIX III

FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS

April 1, 2021 to September 30, 2021

	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	$5,474,272
	Subtotals (A+B)	2	$114,354,689
C.	Reports for which a management decision was made during the reporting period	0	0
D.	Reports for which no management decision has been made by the end of the reporting period	2	$114,354,689
E.	Reports for which no management decision has been made within 6 months of issuance	1	$108,880,417

APPENDIX IV

INSURANCE AUDIT REPORTS ISSUED

April 1, 2021 to September 30, 2021

Report Number	Subject	Date Issued	Questioned Costs
1A-10-17-20-013	Health Care Service Corporation in Chicago, Illinois	April 19, 2021	$87,142
1B-31-00-20-039	Claim Processing Environment at Government Employees Health Association, Inc. in Lee's Summit, Missouri	April 26, 2021	$0
1H-01-00-20-015	Blue Cross Blue Shield's Opioid Claims as Administered by CVS Caremark for the Service Benefit Plan in Contract Years 2017 through 2019 in Washington, D.C.	May 26, 2021	$0
1C-GG-00-20-025	Geisinger Health Plan in Danville, Pennsylvania	June 15, 2021	$553,257
1C-8W-00-20-017	UPMC Health Plan, Inc. in Pittsburgh, Pennsylvania	June 28, 2021	$13,786,995
1H-99-00-20-016	Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts in Washington, D.C.	July 29, 2021	$0
1D-2G-00-21-002	Supplemental Audit of CareFirst BlueChoice, Inc. in Owings Mills, Maryland	August 19, 2021	$7,835,662
1N-0A-00-20-023	Flexible Spending Account for Federal Employees as Administered by Wageworks, Inc. from September 1, 2016, through December 31, 2018 in Louisville, Kentucky	February 21, 2021	$0
1A-99-00-20-018	Enrollment at All Blue Cross and Blue Shield Plans for Contract Years 2018-2019 in Washington, D.C.	March 12, 2021	$412,570
1B-47-00-20-036	Claims Testing Audit of the Claim Processing Environment at American Postal Workers Union Health Plan in Glen Burnie, Maryland	March 26, 2021	$0
TOTAL			**$22,675,626**

APPENDIX V

INTERNAL AUDIT REPORTS ISSUED

April 1, 2021 to September 30, 2021

Report Number	Subject	Date Issued
4A-CF-00-21-008	U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021
4A-CI-00-20-034	U.S. Office of Personnel Management's Office of the Chief Information Officer's Revolving Fund Programs in Washington, D.C.	September 9, 2021
4A-CF-00-20-035	U.S. Office of Personnel Management's Check Receipt Process in Trust Funds in Washington, D.C.	September 30, 2021

APPENDIX VI

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

April 1, 2021 to September 30, 2021

Report Number	Subject	Date Issued
1A-10-78-20-045	Information Systems General and Application Controls at Blue Cross Blue Shield of Minnesota in St. Paul, Minnesota	July 12, 2021
4A-CF-00-21-009	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	September 9, 2021
1A-10-18-21-007	Information Systems General and Application Controls at Anthem, Inc. in Richmond, Virginia	September 13, 2021
1C-SF-00-21-005	Information Systems General and Application Controls at SelectHealth in Murray, Utah	September 13, 2021
4A-CF-00-21-010	Information Technology Security Controls of the U.S. Office of Personnel Management's Benefits Financial Management System in Washington, D.C.	September 14, 2021
4A-ES-00-21-020	Information Technology Security Controls of the U.S. Office of Personnel Management's Executive Schedule C System in Washington, D.C.	September 30, 2021

APPENDIX VII

DATA BRIEFS ISSUED

April 1, 2021 to September 30, 2021

Report Number	Subject	Date Issued
4A-HI-00-18-026	FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C.	April 1, 2021

APPENDIX VIII

EVALUATION REPORTS ISSUED

April 1, 2021 to September 30, 2021

Report Number	Subject	Date Issued
4K-FS-00-20-042	Evaluation of OPM's Response to the COVID-19 Pandemic in Washington, D.C.	May 6, 2021

APPENDIX IX

SUMMARY OF REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

As of September 30, 2021

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

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[4]	Total
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013	1		16
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1		1
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	3		4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	3		29
4K-RS-00-14-076	The Review of the U.S. Office of Personnel Management's Compliance with the Freedom of Information Act in Washington, D.C.	March 23, 2015	2		3
4A-RI-00-15-019	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015	2		7
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	3		27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	4		5
4A-CF-00-16-026	The U.S. Office of Personnel Management's Fiscal Year 2015 Improper Payments Reporting in Washington, D.C.	May 11, 2016	1		6
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, D.C.	July 8, 2016	4		6
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	4		4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	5		26
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	14		19
1C-JP-00-16-032	Information Systems General and Application Controls at United Healthcare in Plymouth, Minnesota	January 24, 2017		1	2
4A-CF-00-17-012	The U.S. Office of Personnel Management's Fiscal Year 2016 Improper Payments Reporting in Washington, D.C.	May 11, 2017	1		10
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	3		4
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York	June 30, 2017		1	15

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[4]	Total
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	7		8
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	14		39
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	15		18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	19		21
4A-CI-00-18-022	Management Advisory Report - the U.S. Office of Personnel Management's Fiscal Year 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018	2		4
4K-RS-00-17-039	The U.S. Office of Personnel Management's Retirement Services' Imaging Operations in Washington, D.C.	March 14, 2018	1		3
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5		5
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1		2
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018	2		4
1C-PG-00-17-045	Information Systems General and Application Controls at Optima Health Plan in Virginia Beach, Virginia	May 10, 2018	1	20	
4A-CI-00-18-044	Management Advisory Report - U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, D.C.	June 20, 2018	2		2
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	21		52
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, D.C.	November 15, 2018	20		23
4K-CI-00-18-009	The U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, D.C.	December 21, 2018	1		3
1C-UX-00-18-019	Information Systems General and Application Controls at Medical Mutual of Ohio in Cleveland, Ohio	January 24, 2019		1	12
1C-8W-00-18-036	Information Systems General Controls at University of Pittsburgh Medical Center Health Plan in Pittsburgh, Pennsylvania	March 1, 2019		1	5
1C-LE-00-18-034	Information Systems General and Application Controls at Priority Health Plan in Grand Rapids, Michigan	March 5, 2019		1	10

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[4]	Total
4A-CI-00-18-037	The U.S. Office of Personnel Management's Compliance with the Federal Information Technology Acquisition Reform Act in Washington, D.C.	April 25, 2019	5		5
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, D.C.	June 3, 2019	3		4
4A-CI-00-19-006	Information Technology Security Controls of the U.S. Office of Personnel Management's Enterprise Human Resource Integration Data Warehouse in Washington, D.C.	June 17, 2019	3		13
4K-ES-00-18-041	Evaluation of the U.S. Office of Personnel Management's Employee Services' Senior Executive Service and Performance Management Office in Washington, D.C.	July 1, 2019	4		6
1C-59-00-19-005	Information Systems General and Application Controls at Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions in Downey and Corona, California	July 23, 2019		2	2
4A-CF-00-19-026	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	October 3, 2019	3		3
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, D.C.	October 23, 2019	13		23
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	23		47
4A-CF-00-19-025	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act of 2014 in Washington, D.C.	November 6, 2019	2		2
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, D.C.	November 18, 2019	20		20
4K-ES-00-19-032	Evaluation of the Presidential Rank Awards Program in Washington, D.C.	January 17, 2020	4		4
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	March 31, 2020	2		2
4A-RS-00-18-035	U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	4	8	12
1A-10-85-17-049	Claims Processing and Payment Operations at CareFirst Blue Cross Blue Shield in Owings Mills, Maryland	April 15, 2020		1	`10
4A-CF-00-20-014	U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020	3		3

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[4]	Total
4A-CI-00-20-007	Information Technology Security Controls of the U.S. Office of Personnel Management's Electronic Official Personnel Folder System Report in Washington, D.C.	June 30, 2020	2		3
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	5		8
4A-DO-00-20-041	Management Advisory Report - Delegation of Authority to Operate and Maintain the Theodore Roosevelt Federal Building and the Federal Executive Institute in Washington, D.C.	August 5, 2020	3		4
1B-32-00-20-004	Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia	September 9, 2020		6	19
4A-CI-00-20-009	U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020	11		11
4A-HI-00-19-007	U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, D.C.	October 30, 2020	12	1	24
4A-RS-00-19-038	U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, D.C.	October 30, 2020		8	8
4A-CI-00-20-008	Information Technology Security Controls of the U.S. Office of Personnel Management's Agency Common Controls in Washington, D.C.	October 30, 2020	4		4
4A-CI-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020	24		45
4A-CF-00-20-024	The U.S. Office of Personnel Management's Fiscal Year 2020 Consolidated Financial Statements in Washington, D.C.	November 13, 2020	21		21
1C-52-00-20-011	Information Systems General and Application Controls at Health Alliance Plan of Michigan in Troy, Michigan	November 30, 2020	1	2	14
1C-A8-00-20-019	Information Systems General Controls at Baylor Scott and White Health Plan in Dallas, Texas	December 14, 2020		7	12
1A-99-00-19-002	Duplicate Claim Payments at All Blue Cross Blue Shield Plans in Washington, D.C.	February 12, 2021		2	8
1A-10-36-20-032	Information Systems General and Application Controls at Capital BlueCross in Harrisburg, Pennsylvania	February 21 2021		3	7
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021		2	2
1A-99-00-20-018	Enrollment at All Blue Cross and Blue Shield Plans for Contract Years 2018-2019 in Washington, D.C.	March 12, 2021		1	5

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

APPENDIX X

MOST RECENT PEER REVIEW RESULTS

As of September 30, 2021

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

Subject	Date of Report	Result
System Review Report on the U.S. Office of Personnel Management Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, Tennessee Valley Authority)*	July 8, 2021	Pass[5]
System Review Report on the NASA Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	August 13, 2018	Pass
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management *(Issued by the Office of Inspector General, Corporation for National and Community Service)*	December 2, 2016[6]	Compliant[7]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Special Inspector General for Afghanistan Reconstruction *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	March 10, 2020	Compliant
External Peer Review Report on the Office of Evaluations of the Office of the Inspector General for the U.S. Office of Personnel Management *(Issued by the U.S. Consumer Product Safety Commission Office of Inspector General)*	December 16, 2019	Compliant[8]
External Peer Review Report on the Office of the Inspector General for the Library of Congress *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	July 22, 2021	Compliant

[5] A peer review rating of "Pass" is issued when the reviewing OIG concludes that the system of quality control for the reviewed OIG has been suitably designed and complied with to provide 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.

[6] Due to the COVID pandemic, the latest Peer Review of the Office of Investigations was postponed and has been tentatively rescheduled for January 2022.

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

[8] A rating of "Compliant" conveys that the reviewed OIG has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards for Inspections and Evaluations are followed.

APPENDIX XI

INVESTIGATIVE RECOVERIES

APRIL 1, 2021 – SEPTEMBER 30, 2021

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			$2,626,694	$1,461,360
	Healthcare & Insurance		$1,744,789	$579,455
		Carrier Settlements	$1,744,789	$579,455
	Retirement Services		$881,905	$881,905
		Administrative Debt Recoveries	$781,181	$781,181
		Voluntary Repayment Agreements	$100,724	$100,724
Civil			$71,580,586	$595,824
	Healthcare & Insurance		$71,580,586	$595,824
		Civil Actions	$71,580,586	$595,824
Criminal			$1,021,022	$377,906
	Healthcare & Insurance		$463,050	$188,693
		Court Assessments/Fees	$500	$0
		Criminal Fines	$57,891	$0
		Criminal Judgments/Restitution	$463,050	$188,693
	National Background Investigations		$86,562	$0
		Court Assessments/Fees	$100	$0
		Criminal Fines	$4,000	$0
		Criminal Judgments/Restitution	$86,562	$0
	Retirement Services		$471,410	$189,213
		Court Assessments/Fees	$400	$0
		Criminal Fines	$0	$0
		Criminal Judgments/Restitution	$471,410	$189,213
TOTAL			**$75,228,302**	**$2,435,090**

INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)

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of this publication, please contact:

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