Office of the
Inspector General

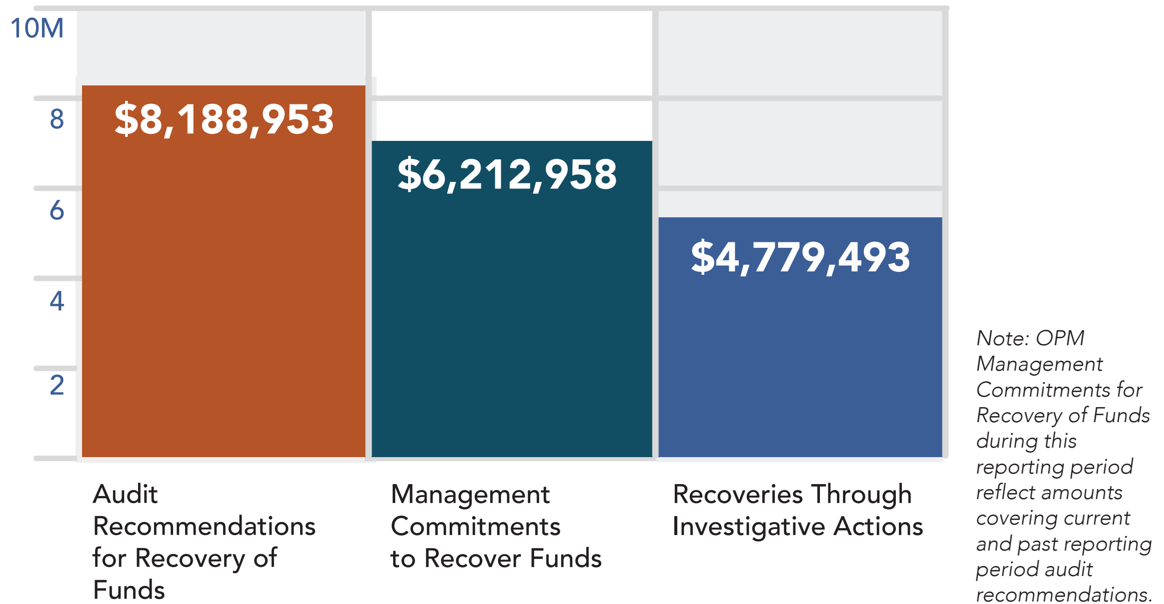
Semiannual Report to Congress

October 1, 2021 – March 31, 2022

United States Office Of Personnel Management

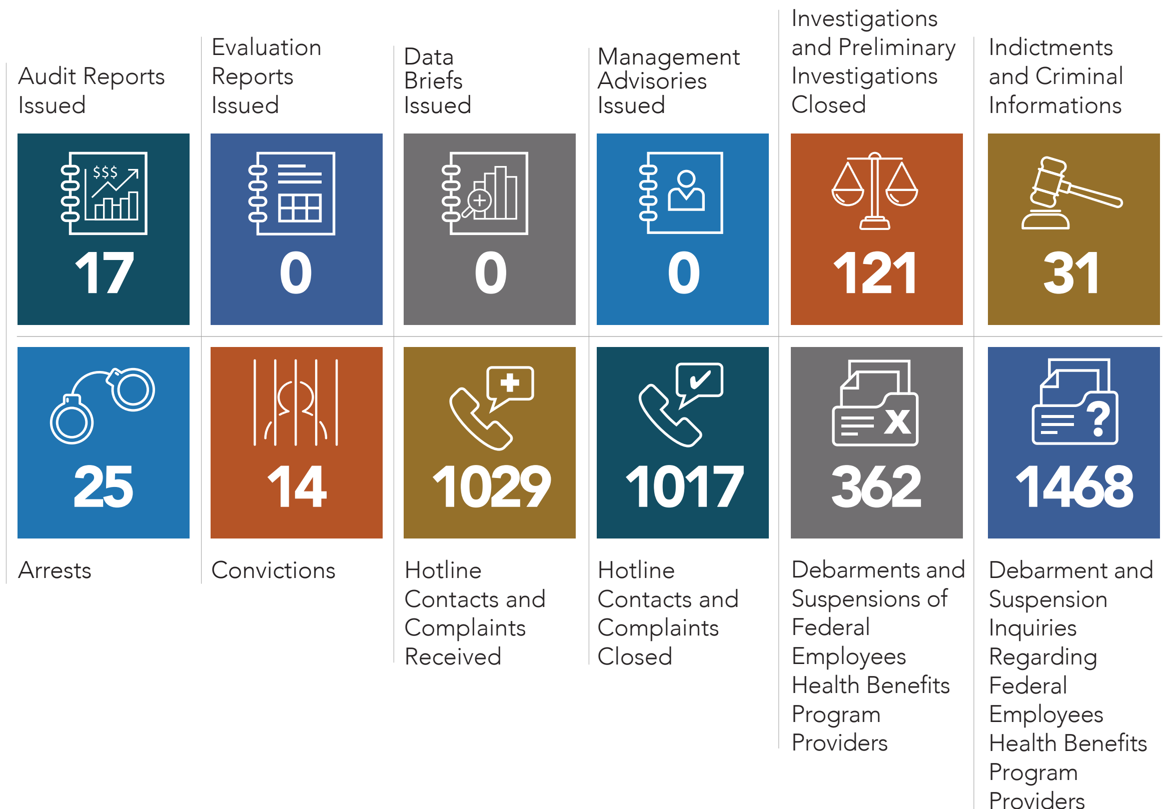
Productivity Indicators

Financial Impact



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

Accomplishments



Over the reporting period, the agency fully closed 133 recommendations. As of March 31, 2022, there are 425 (354 unresolved + 7 resolved) unimplemented recommendations over six months old.

Message from the Deputy Inspector General

During this reporting period, I am pleased to announce the completion of two important U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) initiatives that I believe will improve the way in which our office operates. The first initiative, the issuance on March 11, 2022, from OPM Director Kiran A. Ahuja of an agencywide message and an OIG Directive on the continued cooperation and reporting to the OIG. This was the result of months of work with the Council of the Inspectors General on Integrity and Efficiency (CIGIE), the U.S. Office of Management and Budget (OMB), and close coordination with the OPM Office of General Counsel. As far back as March 2021, CIGIE began assessing communications from agency leaders on issues of OIG cooperation and access. The OPM OIG was one of 52 OIGs that participated in this process, sharing our own agency's communications and lessons learned to help CIGIE identify recommended approaches for such agency communications.

In December 2021, OMB issued a memorandum to the heads of all executive departments and agencies on promoting accountability through cooperation among agencies and their Inspectors General. The OMB guidance included input from CIGIE on leading strategies to strengthen these relationships. The OMB guidance also called for all agencies to reinforce the importance of the relationship between an agency and their OIG by communicating the agency head's expectation that their staff and contractors fully cooperate with the OIG. We are grateful that OPM Director Ahuja fully embraced the call. On March 11, 2022, she shared a message reminding all OPM staff of the important, independent role the OPM OIG plays within the agency. The Director also shared the OIG's first ever agencywide Management Directive on Cooperation with and Reporting to the Office of the Inspector General.

The OIG is responsible for conducting audits and evaluations of all OPM programs and operations. In almost all cases, the information needed to conduct our work is provided to the OIG staff in a timely manner by OPM and contractor personnel. However, in rare situations the OIG staff has encountered delays and resistance to providing information necessary to perform our mandated oversight responsibilities. We believe the issuance of the Director's message to all OPM staff regarding Continued Cooperation with the OIG, and the associated Management Directive, will help to ensure that OIG audits, reviews, evaluations, and investigations can be conducted efficiently and effectively. With this reminder and guidance for dealing with the OIG during audits, reviews, and evaluations, we believe such delays will decrease, to the benefit of both the OIG and OPM.

The Director's message and the OIG's Management Directive also provide OPM staff a better understanding of our legal authority to access information and encourage agency employees to more fully assist and engage with our office. It is my hope that a better understanding of the OIG's mission will lead to better cooperation, which will in turn mean that the OIG's audits, reviews, and evaluations can be conducted more efficiently, timely, and effectively.

Furthermore, the cooperation message and OIG Management Directive will also have a significant positive affect on our investigations. Civil, criminal, and administrative investigations into OPM employees and contractors accused of fraud, waste, or abuse require the cooperation of the agency and its contractors to proceed quickly, effectively, and fairly. These policies will provide encouragement for agency employees to assist and engage with the OIG in those instances where an investigation is necessary.

Investigations can be affected by issues such as timeliness. For example, a statute of limitations may affect investigations by limiting the amount of time after an event within which legal proceedings may be initiated. Cooperation with the agency to reduce the time required for requests of information, or to streamline any back-and-forth in the factfinding or information request process, is beneficial to reducing the number of investigations affected by timeliness issues.

OPM programs are incredibly complex. The contract and coverage requirements of the Federal Employees Health Benefits Program (FEHBP) and the process of disbursing billions of dollars each month for OPM annuitants and FEHBP enrollees requires the expertise of program specialists. OPM also provides human resources leadership and support to Federal agencies as the personnel policy manager for the Federal Government. The OIG relies on our ability to constructively work with agency program specialists to evaluate and oversee governmentwide human resources programs and protect Federal employees and their families whether they are FEHBP enrollees, annuitants, or anyone who relies on OPM benefits and programs.

The second initiative our office completed during this reporting period is the development of our Strategic Plan for Diversity, Equity, Inclusion, and Accessibility (DEIA). On June 25, 2021, President Biden signed Executive Order (E.O.) 14305, DEIA in the Federal Workforce. In the spirit of inclusivity, the OPM OIG formed two workgroups, one composed of employees and the other composed of supervisors, to assist with meeting the E.O. requirement of developing a DEIA Strategic Plan. The workgroups independently provided recommendations to the OPM OIG senior staff on ways the OIG could strengthen DEIA within our work culture. From these recommendations, the OIG senior staff developed a DEIA Strategic Plan.

As part of the plan, the OPM OIG established a DEIA vision and mission:

Vision	Mission
• Empowerment through Inclusion • Opportunity through Equity • Success through Diversity and Accessibility	To ensure the equitable distribution of resources, tools, and opportunities by integrating diversity, inclusion, and accessibility in our work, workplace, and culture.

Other key elements of our DEIA Strategic Plan include the establishment of a Chief Diversity Officer, the enhancement of our safe workplace culture, the increased use of data for evidence-based decision-making, the development of a robust leadership development program, and increased DEIA training and learning opportunities for all staff. I am particularly excited about the development of the new leadership development program. That program will identify skills critical to staff advancement and establish a multiphasic development approach, to include cross training, rotational details, and mentoring.

Finally, later this year, the OPM OIG will be updating its overall Strategic Plan for 2023–2027, and we look forward to consulting with Congress as we move forward with the process. We believe that our DEIA Strategic Plan will serve as a foundational piece of our overall Strategic Plan and help to build a stronger OPM OIG.

Norbert E. Vint
Deputy Inspector General

The Ongoing Impact of COVID-19 on the Federal Employees Health Benefits Program

In our three most recent semiannual reports to Congress, we discussed the impact of COVID-19 on the OPM-administered Federal Employees Health Benefits Program (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 2020 and first half of 2021. As the coronavirus pandemic continues to be a significant concern for the population served by the FEHBP, we have again dedicated a portion of our semiannual report to Congress to the analysis of COVID-19's impact on the FEHBP population.

For this semiannual report to Congress, we analyzed health claims data consisting of a subset of the FEHBP population, covering about 69 percent of enrolled individuals. Consequently, all of 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 January 2022, though a small number of claims for this time period will likely be submitted throughout the remainder of 2022. For this reason, the figures represented in this semiannual report to Congress may vary slightly from those reported in our previous semiannual report to Congress.

Our analysis of COVID-19 diagnoses so far shows relatively small waves in the spring and summer of 2020, with a dip in the fall before cases rose above 1,000 per day in early winter. Calendar year 2021 started with a peak above 3,000 cases in one day before dropping drastically and remaining below 1,000 cases per day into July. There was a slight peak in August and September, reaching about 2,000 cases per day, before falling to less than 1,000 per day in the fall. Finally, we saw a massive peak in cases around January of 2022, reaching 6,000 cases per day, or double the rate of cases previously seen.

Exhibit 1: Total COVID-19 Diagnoses Per Day (January 2020 – January 2022)

Please note figures include only a subset of FEHBP Health Plans

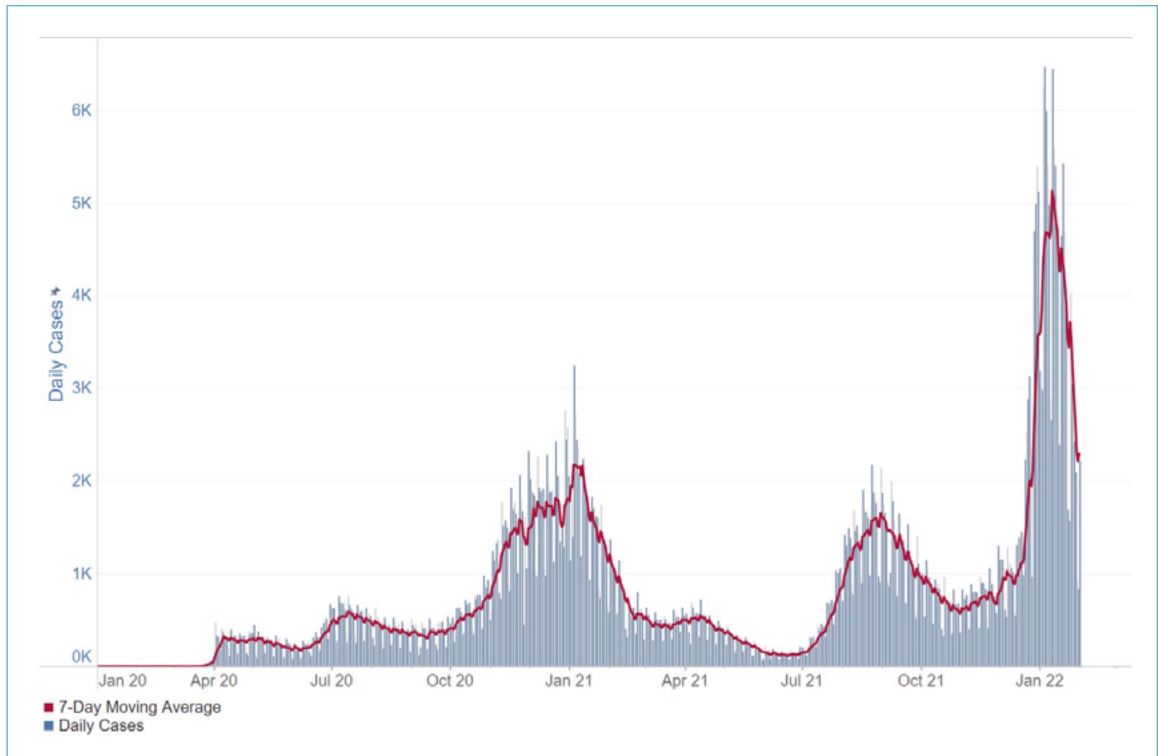


Exhibit 1: Total COVID-19 Diagnoses Per Day (January 2020 – January 2022). This bar graph shows the total COVID-19 diagnoses per day from January 2020 through July 2022. Daily case numbers began reaching the hundreds in April 2020 and reached around 500 in July, with a dip in the fall before cases rose above 1,000 per day in early winter. 2021 started the year with a peak above 3,000 cases in 1 day before dropping drastically in the spring and remaining below 1,000 cases per day into July. There was a slight peak in August and September, reaching about 2,000 cases per day, before falling to less than 1,000 per day in the fall. Finally, we saw a massive peak in cases around January 2022, reaching 6,000 cases per day, or double any previously seen rate.

While we currently only have complete data through January 2022, a comparison of our Exhibit 1 to the Centers for Disease Control and Prevention's (CDC's) daily cases in Exhibit 2 on the next page shows that our data closely resembles the CDC's diagnoses trends as reported on its COVID Data Tracker website.[1]

[1] https://covid.cdc.gov/covid-data-tracker/#trends_dailycases

Exhibit 2: CDC Data on Total Diagnoses Per Day (January 2020 – January 2022)

Please note figures include only a subset of FEHBP Health Plans

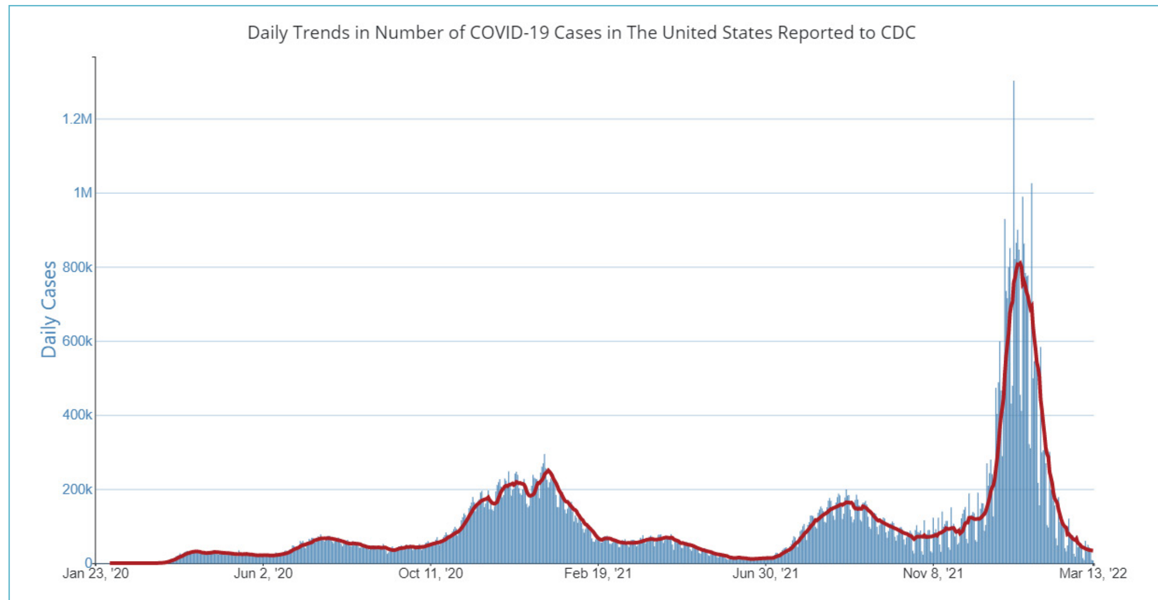


Exhibit 2: CDC Data on Total Diagnoses Per Day (January 2020 – January 2022). This graph, taken from the CDC COVID Data Tracker website, shows the total COVID-19 diagnoses per day from January 2020 to March 2022. Case numbers remained relatively low until late fall of 2020, then rose to around 200,000 per day in November and remained there until a sharp drop around February 2021. Cases began rising sharply around July, fell slightly in the fall, and then peaked over 1.2 million cases in 1 day around January 2022. Cases fell off sharply after January and were well under 100,000 cases per day as of March 13, 2022.

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 FEHBP cases have continued to decline drastically since the end of January 2022.

Continued Impacts to Preventive Care Due to COVID-19

In our last three semiannual reports to Congress, we expressed concerns regarding preventive care utilization by FEHBP members. While in our last semiannual report to Congress we demonstrated that preventive care utilization had increased significantly in the second half of 2020, and continuing in the first half of 2021, it was still not high enough to offset the procedures missed during the height of COVID-19 lockdowns. This continues to be the case.

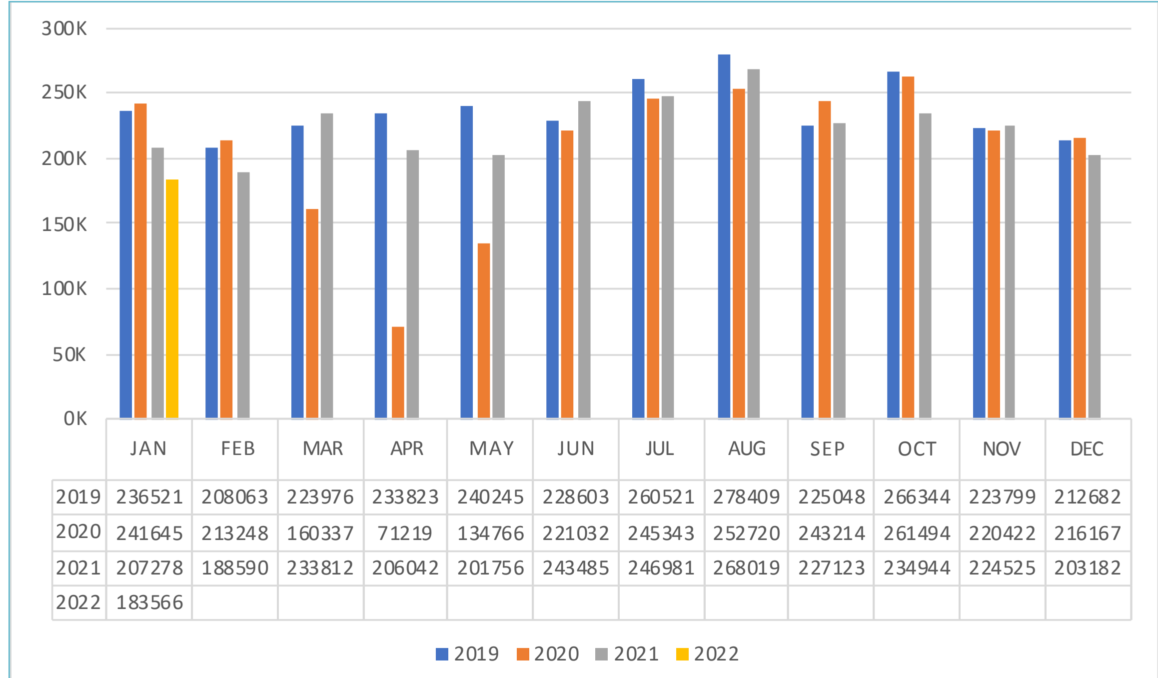
The number of individuals covered by the FEHBP health care carriers included in our analysis increased by 1.54 percent from 2019 to 2020. We now know that there was an additional 1 percent increase in covered individuals in our sample from 2020 to 2021. As such, we should have seen a routine increase in preventive care utilization of about 2–3 percent for 2021 compared to pre-pandemic levels in 2019. It is important to keep in mind that this increase in utilization would appear to be a return to normal levels but would not necessarily make up for all of the missed procedures in 2020. In 2021, this expected routine increase was only observed in March and June.

In fact, in most months in 2021, preventive care utilization remained an average of 5 percent lower than 2019 levels. In January 2022, while COVID-19 cases were again peaking, preventive

care utilization levels were 22 percent lower than January 2019. When considering the increase in member enrollment, this is about 24–25 percent lower than expected, potentially suggesting about 59,000 preventive care services missed in January 2022 alone.

Exhibit 3: Preventive Care Claims Per Month Compared by Year (January 2019 – January 2022)

Please note figures include only a subset of FEHBP Health Plans



	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2019	236521	208063	223976	233823	240245	228603	260521	278409	225048	266344	223799	212682
2020	241645	213248	160337	71219	134766	221032	245343	252720	243214	261494	220422	216167
2021	207278	188590	233812	206042	201756	243485	246981	268019	227123	234944	224525	203182
2022	183566											

Exhibit 3: Preventive Care Claims Per Month Compared by Year (January 2019 – January 2022). This multi-bar graph shows the number of preventive care claims per month for the years 2019–2022. Compared to 2019, the bars for 2020 are slightly higher in January and February, drastically lower in March, April, and May, slightly lower in June, July, and August, somewhat higher in September, slightly lower again in October and November, and very slightly higher in December. Compared to 2019, the bars for 2021 are higher in March and June, comparable in September and November, but are otherwise lower. The bar for January of 2022 is notably lower than January of all prior years.

Aside from the spike in COVID-19 cases around this time, another factor that may be exacerbating this effect is a widespread health care staffing shortage. According to healthdata.gov, over 1,000 hospitals reported critical staffing shortages in January 2022.[2]

[2] https://healthdata.govGovernment-wide/Hospital/COVID-19-Reported-Patient-Impact-and-Hospital-Capa/g62h-syeh

Exhibit 4: Number of Hospitals Reporting Critical Staffing Shortages (January 2020 – January 2022)

Please note figures include only a subset of FEHBP Health Plans

Exhibit 4: Number of Hospitals Reporting Critical Staffing Shortages (January 2020 – January 2022). This line graph, created with data from healthdata.gov, shows the trend in the number of hospitals in the U.S. reporting critical staffing shortages from January 2020 to January 2022. The line stays near zero until July of 2020, when it rises sharply to nearly 800. The number increases steadily to a peak above 1,200 in January 2021, before falling steadily until March where it remains steady around 650 through August, before rising again to almost 1,000. The line reaches about 1,100 in January 2022, where it appears to begin falling off sharply, ending around 700 by the end of January 2022.

In a country with just over 6,000 hospitals,[3] this means 1 in every 6 hospitals experienced a critical staffing shortage in January 2022. Furthermore, as shown in Exhibit 4 once the level of staffing shortages spiked around July 2020, it had not significantly declined by January 2022. Without adequate staffing levels, nonessential procedures and visits are cancelled, as recommended by the CDC.[4] This could mean continued missed services and missed opportunities for early detection of treatable diseases.

Further, while some types of preventive care services in Exhibit 3 are returning closer to pre-pandemic levels, others are not coming close. Rates of preventative care in pediatric immunizations continue to be observed at lower rates than those seen in 2019.

[3] https://www.aha.org/statistics/fast-facts-us-hospitals
[4] https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Exhibit 5: Overall Pediatric Immunization Rate (January 2017 – January 2021)

Please note figures include only a subset of FEHBP Health Plans

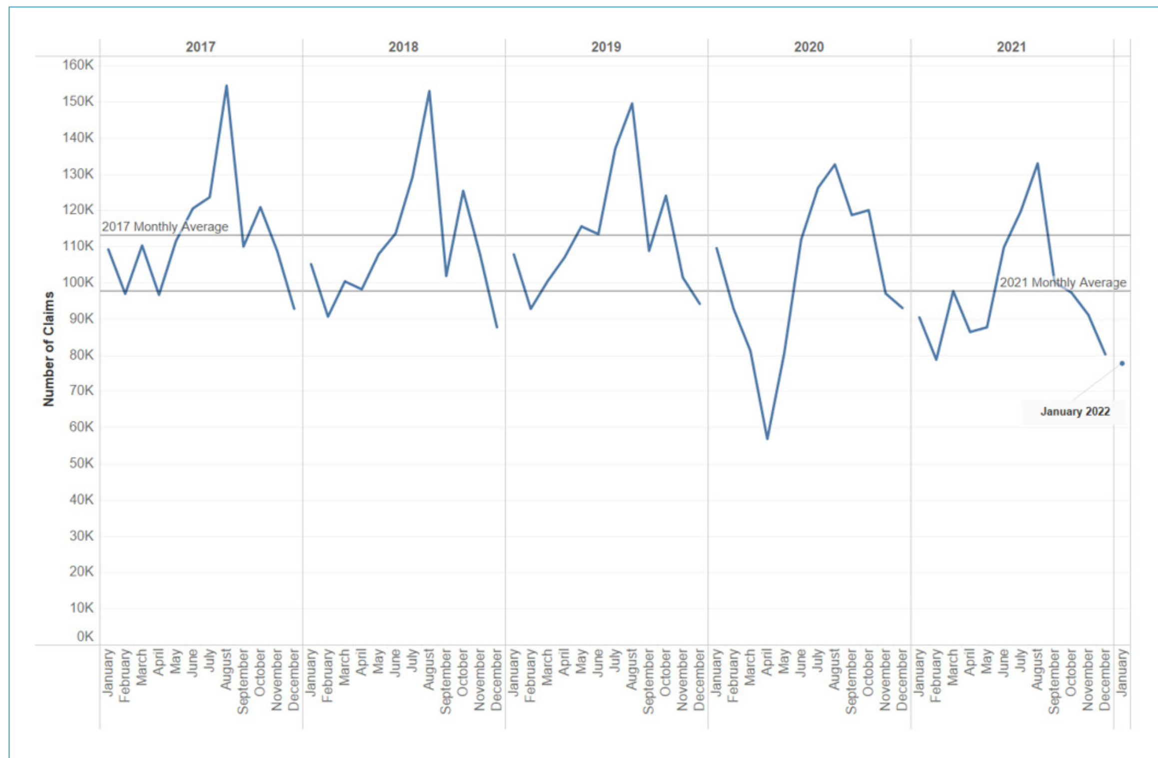


Exhibit 5: Overall Pediatric Immunization Rate (January 2017 – January 2022). This line graph shows the trend in the number of claims for pediatric immunizations from January 2019 to January 2022. There are average bars for the average number of monthly claims for 2019 and 2021. The average for 2021, around 98,000, is significantly lower than the average for 2019, which was around 113,000. The mark for January of 2022, around 78,000, is lower than any point in 2019.

As mentioned in our previous semiannual report to Congress, this is not a new or unrecognized phenomenon. This downward trend in pediatric immunization rates has been reported on by the American Academy of Pediatrics,[5] the World Health Organization,[6] the CDC,[7] and the Washington Post.[8] 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. In fact, the rate of pediatric immunization was significantly lower in January 2022 than any month in 2017, 2018, or 2019. This is particularly concerning now, given that most children have returned to in-person schooling, greatly increasing the risk of outbreaks of vaccine-preventable diseases among unvaccinated children.

[5] https://pediatrics.aappublications.org/content/148/1/e2020047092
[6] https://www.who.int/news/item/15-07-2021-covid-19-pandemic-leads-to-major-backsliding-on-childhood-vaccinations-new-who-unicef-data-shows
[7] https://www.cdc.gov/vaccines/parents/visit/vaccination-during-COVID-19.html
[8] https://www.washingtonpost.com/health/2021/06/10/childhood-vaccination-falloff-increased-risk-disease-outbreaks/

Occurrence of Metastases in Various Types of Cancer

In our preventive care analysis in previous semiannual reports to Congress, as well as in our preventive care services data brief,[9] we have included trends in utilization of some routine cancer screening services, including mammograms and prostate exams. We expressed concerns that delays in obtaining these services could lead to later-stage diagnoses of certain types of cancer, which in turn could lead to an increase in aggressive therapies and negative side effects.

Looking at rates of change since 2017, as shown in Exhibit 6, we did see a decrease in overall diagnoses of a few types of cancer in 2020, including breast cancer, colorectal cancer, lung cancer, and prostate cancer. These are the types of cancer for which routine preventive care exists and is recommended, at least for high-risk individuals. It follows logically that as preventive care visits were missed, so too were diagnoses of these cancers. On the other hand, diagnoses of types of cancer for which routine screening is not recommended, including ovarian and pancreatic cancers, did not decrease in 2020.

Exhibit 6: Trend in the Percent Increase/Decrease of Cancer Diagnoses for Cancers with Recommended Preventive Screening (2017 – 2021)

Please note figures include only a subset of FEHBP Health Plans

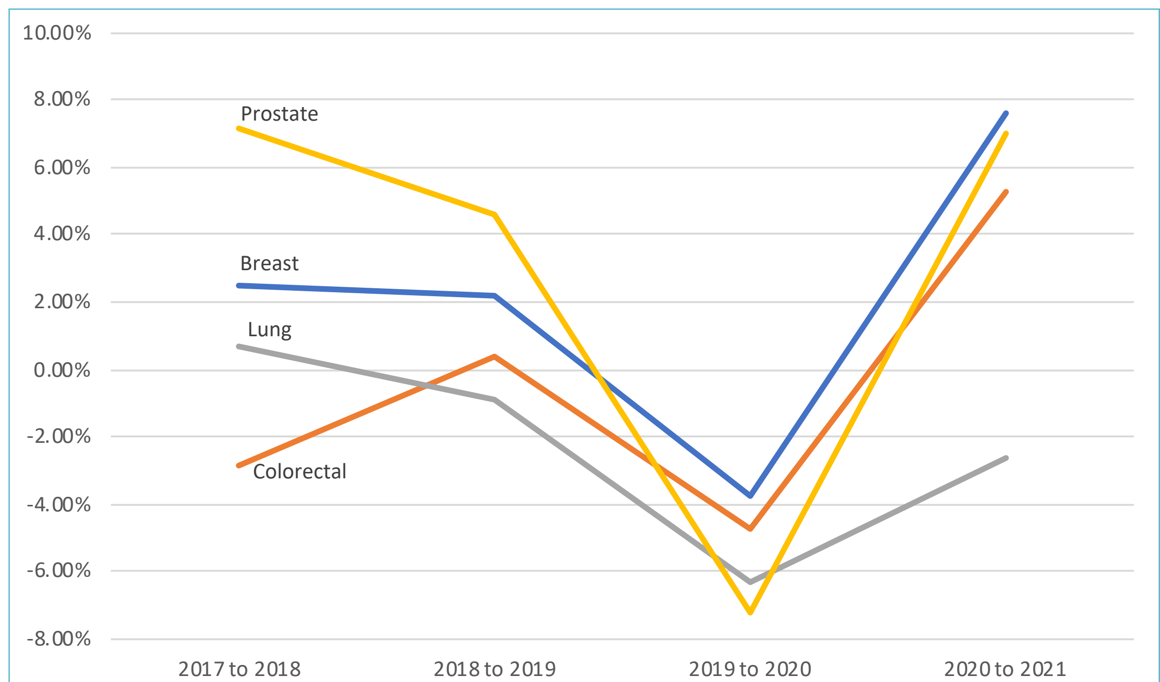


Exhibit 6: Trend in the Percent Increase/Decrease of Cancer Diagnoses for Cancers with Recommended Preventive Screening (2017 – 2021). This line graph shows the percent change from year to year for diagnoses of four types of cancer: breast cancer, colorectal cancer, lung cancer, and prostate cancer. All four lines take a sharp dip from 2019 to 2020, then increase drastically from 2020 to 2021. Specifically, from 2018 to 2019, diagnoses of prostate, breast, lung, and colorectal cancer changed +7 percent, +2.5 percent, +0.7 percent, and -3 percent, respectively. Then from 2019 to 2020, diagnoses of these same cancers each decreased, by -4.5 percent, -4 percent, -6 percent, and -5 percent respectively. Finally, from 2020 to 2021, the rates of change were +7 percent, +7.5 percent, -2.5 percent, and +5 percent.

[9] https://www.opm.gov/our-inspector-general/publications/reports/2021/1k-99-00-20-046.pdf

Exhibit 7: Trend in the Percent Increase/Decrease of Cancer Diagnoses for Cancer *Without* Recommended Preventive Screening (2017-2021)

Please note figures include only a subset of FEHBP Health Plans

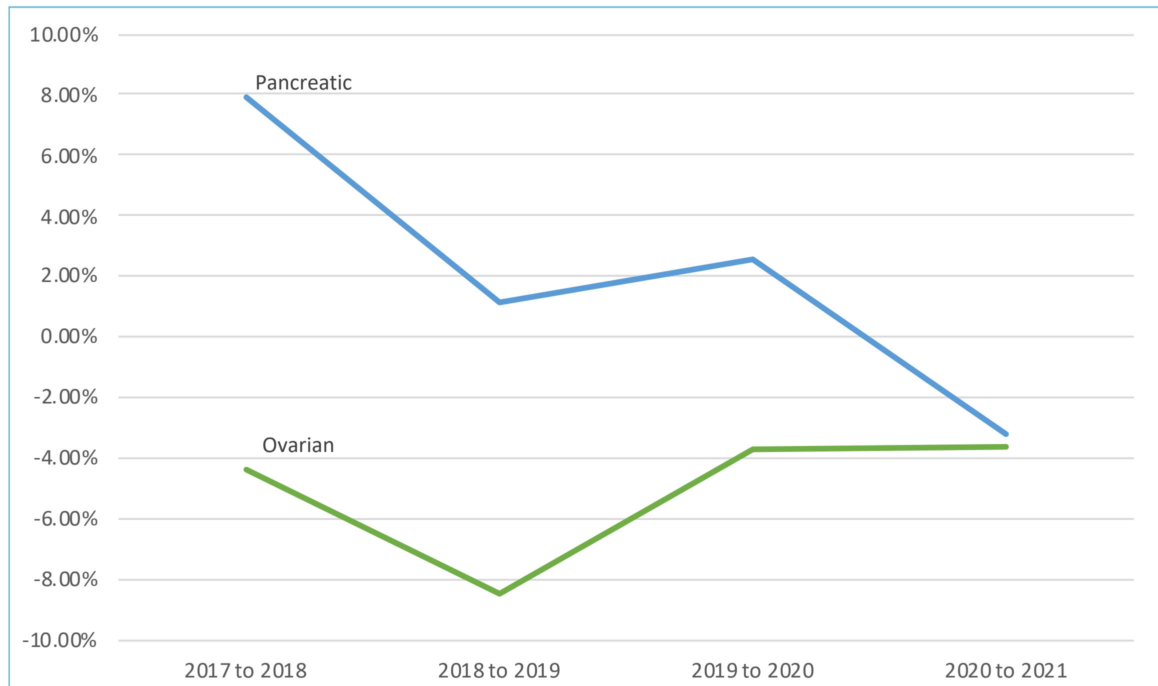


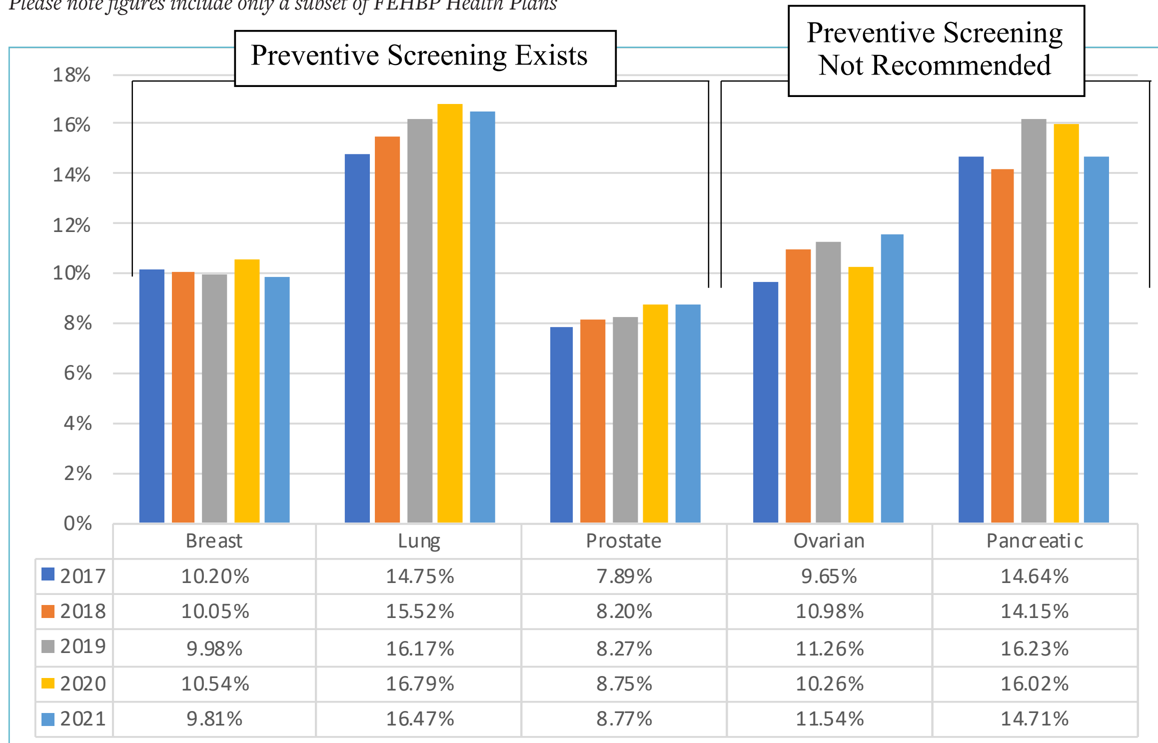
Exhibit 7: Trend in the Percent Increase/Decrease of Cancer Diagnoses for Cancer *Without* Recommended Preventive Screening (2017-2021). This line graph shows the percent change from year to year for two types of cancer: ovarian cancer and pancreatic cancer. From 2017 to 2018, ovarian cancer decreased about 4 percent, while pancreatic cancer increased about 8 percent. From 2018 to 2019, ovarian cancer decreased further, with an 8 percent decrease, while pancreatic cancer again increased, but much less drastically, with only a 1 percent increase, as opposed to the 8 percent increase seen from 2017 to 2018. From 2019 to 2020, this trend reversed for both types of cancer. Ovarian cancer decreased less than four percent during this period, while pancreatic cancer rose more than 2 percent. From 2020 to 2021, the drop in ovarian cancer remained relatively steady at just less than a 4 percent increase, while pancreatic cancer actually decreased for the first time, by about 3 percent.

To examine this further, we analyzed the percent of cancer cases that included diagnoses of secondary neoplasm, as shown in Exhibit 8. Secondary neoplasm refers to cancer that has spread (metastasized) from the place where it originated to other parts of the body.[10] The results of our claims analysis seem to support that when preventive screening fell in 2020, rates of secondary neoplasms increased for those types of cancer where preventive screening can normally detect some cases early, before the cancer has a chance to metastasize.

[10] https://www.cancer.gov/publications/dictionaries/cancer-terms/def/secondary-cancer

Exhibit 8: Percent of Cancer Diagnoses with Secondary Neoplasm (2017-2021)

Please note figures include only a subset of FEHBP Health Plans



	Breast	Lung	Prostate	Ovarian	Pancreatic
2017	10.20%	14.75%	7.89%	9.65%	14.64%
2018	10.05%	15.52%	8.20%	10.98%	14.15%
2019	9.98%	16.17%	8.27%	11.26%	16.23%
2020	10.54%	16.79%	8.75%	10.26%	16.02%
2021	9.81%	16.47%	8.77%	11.54%	14.71%

Exhibit 8: Percent of Cancer Diagnoses with Secondary Neoplasm (2017 – 2021). This bar graph compares the yearly percent of cancer diagnoses that included diagnoses of secondary neoplasm for five types of cancer. Preventive screening exists for three of these cancers: breast, lung, and prostate. Preventative screening does not exist or is not recommended for the two other cancers: ovarian and pancreatic. For the three cancers which have preventive screenings, the rate of secondary neoplasm increased in 2020. For those cancers which do not generally have early or preventive screening, the rate of secondary neoplasm appears to have dropped in 2020.

The good news is the increase in occurrence of secondary neoplasm was relatively small for all types of cancer we analyzed. However, we do not wish to make light of these effects, given that this small percentage increase corresponds to about 1,400 additional FEHBP members suffering from cancer which has metastasized, increasing the need for aggressive treatments, which can lead to the devastating side effects mentioned in our preventive care data brief.[11] Nevertheless, we do recognize that, as of now, it appears the effects of the decrease in preventive care utilization since the beginning of the pandemic have not been as severe as they could have been.

Ongoing analysis is required to observe the continued effects, especially given the fact that preventive care continues to be utilized at a lower rate now than in 2019. When pairing this trend with the aforementioned staffing shortages, effects could continue well into the future. In fact, early estimates made within the first year of the pandemic suggested that delays in screening and cancer care could lead to about 10,000 excess deaths from breast and colorectal cancer alone.[12] This analysis assumed a return to pre-pandemic levels of service within six months, an optimistic postulation that unfortunately was not achieved. Medical experts will likely continue to study COVID-19's effects on seemingly unrelated health outcomes for years to come.

[11] https://www.opm.gov/our-inspector-general/publications/reports/2021/1k-99-00-20-046.pdf
[12] https://time.com/5884236/coronavirus-pandemic-cancer-care/

Telehealth

We had previously reported that telehealth utilization in the FEHBP population, increased over 5,000 percent from 2019 to 2020. As shown in Exhibit 9, telehealth utilization throughout 2021 did decrease in comparison to 2020. However, we still saw an average of 507,000 telehealth claims per month in 2021, as compared to only 11,000 per month in 2019. In addition, we did see a small spike again in January of 2022, coinciding with the drastic increase in COVID-19 cases. This shows that increased use of telehealth services by FEHBP members in lieu of in-person appointments is likely here to stay and will require oversight to ensure the safety of FEHBP members and the security of personally identifiable information and protected health information captured during telehealth visits.

Exhibit 9: Trend in Telehealth Claims from January 2019 to January 2022

Please note figures include only a subset of FEHBP Health Plans

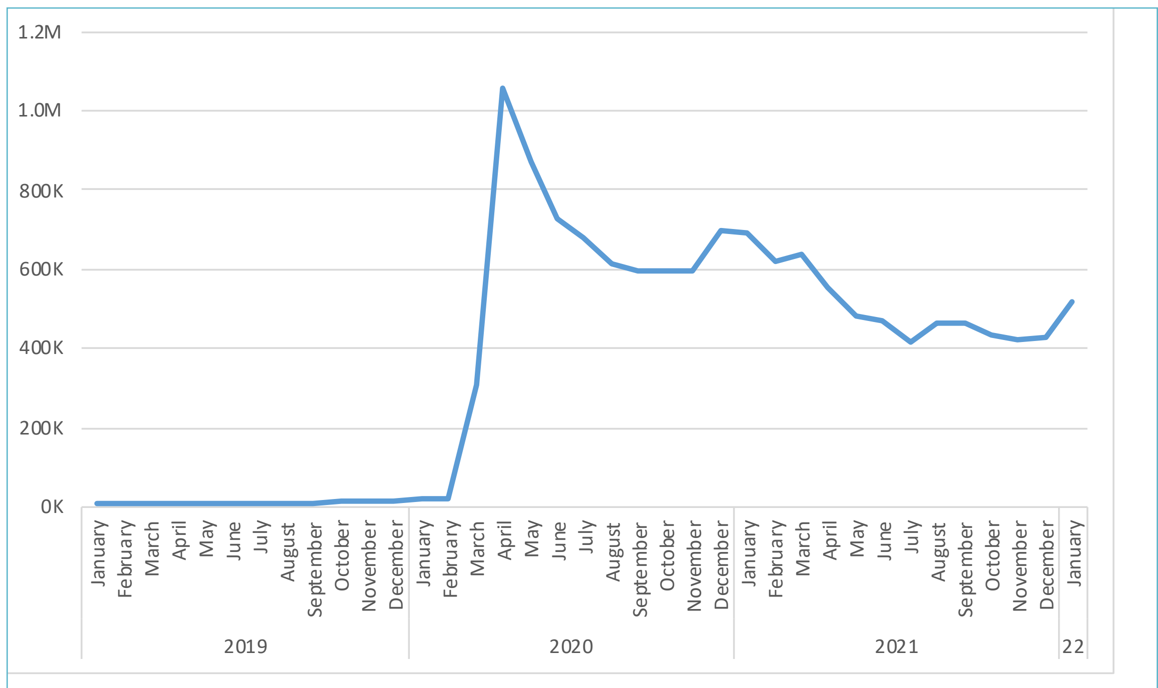


Exhibit 9: Trend in Telehealth Claims from January 2019 to January 2022. This line graph depicts the trend in telehealth claims from January 2019 – January 2022. The line graph almost touches the zero axis for most of 2019, rising ever so slightly in December of 2019 through February of 2020. After February of 2020, the line peaks drastically in March and April, rising above 1 million claims per month. The line then falls from April to August, remains steady at about 600,000 claims per month through November, then rises slightly in December 2020. Telehealth claims stayed between 600,000 and 700,00 per month from January 2021 to March 2021, then fell to around 400,000 in April. In January of 2022, telehealth utilization rose again, to over 500,000 claims in the month.

Open Audit Recommendations Accumulation

In our two most recent annual Top Management Challenges reports, we discussed open audit recommendations. OPM currently has over 400 open recommendations greater than six months old, two of which date all the way back to 2008. Of these open recommendations, over 130 are duplicates, meaning a recommendation has been made in a subsequent audit, potentially for multiple years in a row. This is an issue that compounds upon itself and has worsened over the past 5–10 years.

Exhibit 1: Open Recommendations by Year

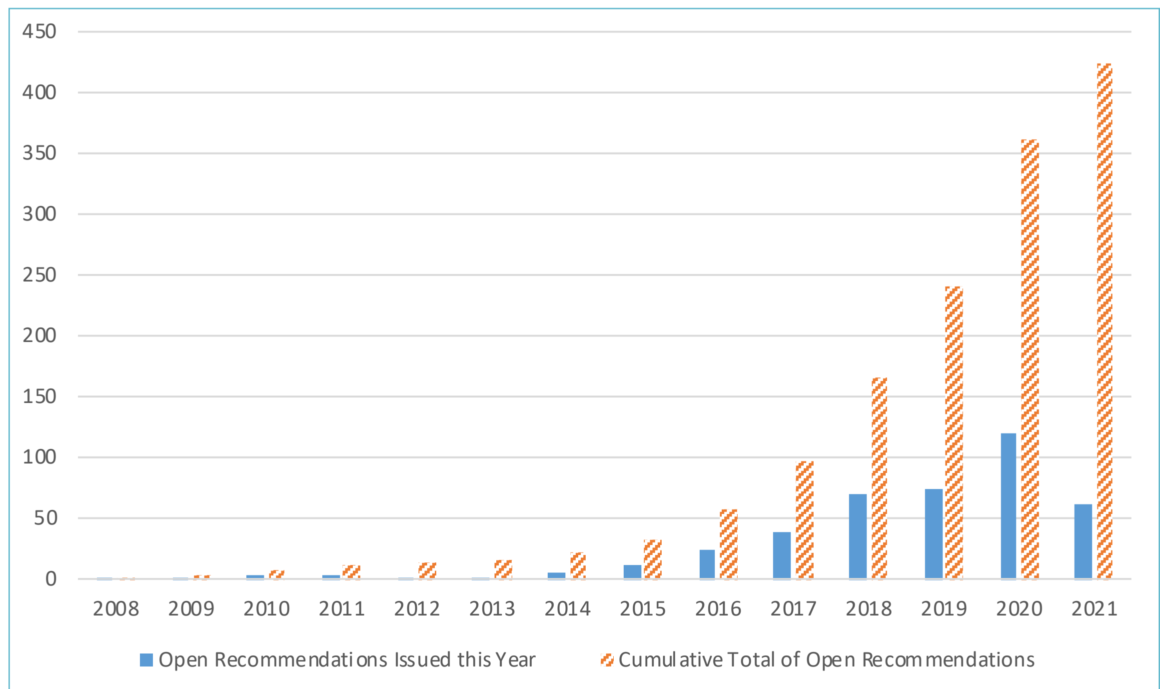


Exhibit 1: Open Recommendations by Year. This multi-bar graph shows the number of open recommendations issued per year and the number of cumulative open recommendations over time. The graph starts in 2008 with two recommendations, shown in both the new and cumulative bars. The number of cumulative open recommendations stays below 30 until 2015, after which it begins to substantially accumulate with 58 cumulative open recommendations in 2016, 97 in 2017, and 166 in 2018. The chart ends in 2021 (January through September only) with 422 cumulative recommendations open for more than six months.

However, there is a noteworthy distinction in the types of recommendations that remain open long-term. Currently, recommendations made to offices internal to OPM account for 89 percent of open recommendations and date back to 2008. This is despite the fact that recommendations to internal OPM offices made up only 31 percent of the recommendations the OIG has issued since 2008, as shown in Exhibits 2 and 3.

Exhibit 2: Percentage of All Recommendations Made Since 2008: Internal Versus External Entities

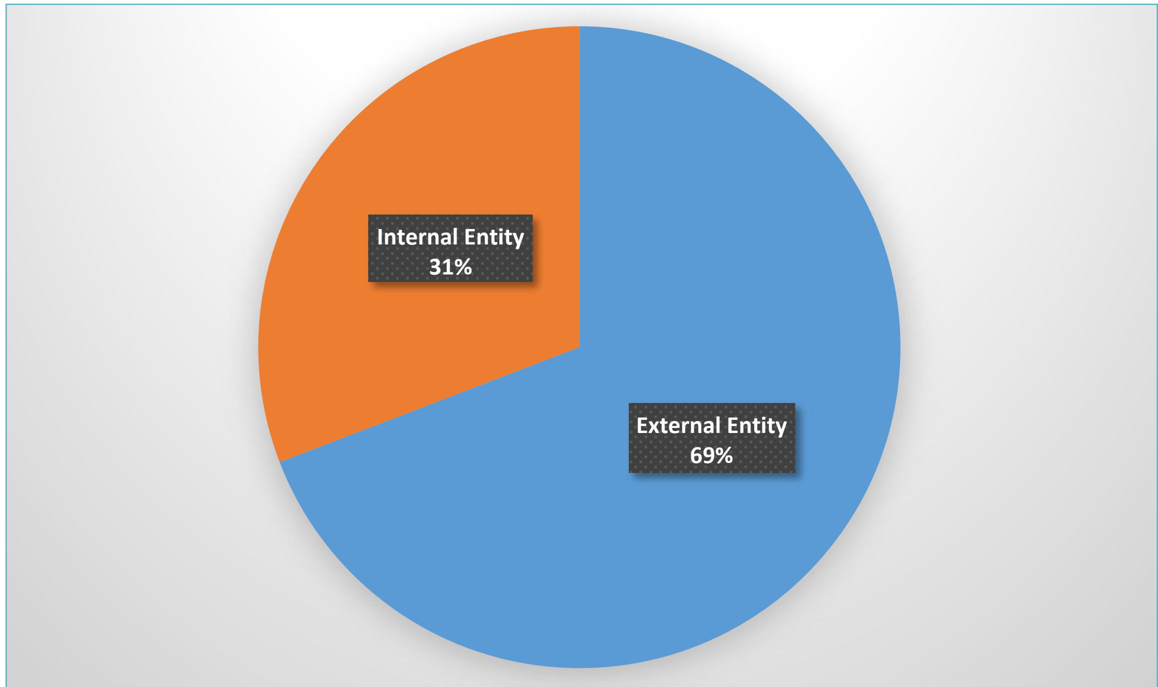


Exhibit 2: Percentage of All Recommendations Made Since 2008: Internal Versus External Entities. This pie chart shows the percentage of all recommendations made since 2008, divided by recommendations made to internal versus external entities. Sixty-nine percent of recommendations were made to external entities, while thirty-one percent were made to internal entities.

Exhibit 3: Percentage of Open Recommendations: Internal Versus External Entities

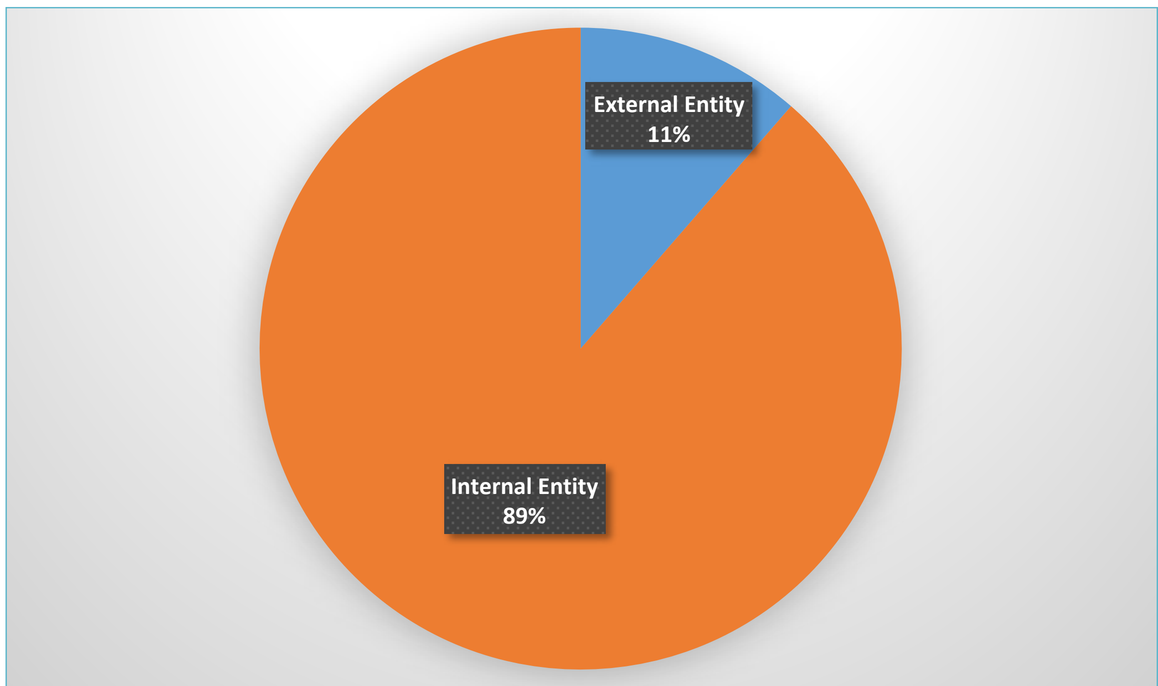


Exhibit 3: Percentage of Open Recommendations: Internal Versus External Entities. This pie chart shows the percentage of all currently open recommendations, divided into recommendations made to internal entities versus recommendations made to external entities. Eighty-nine percent of open recommendations were made to internal entities, as opposed to only eleven percent made to external entities.

Exhibit 4: Open Internal Recommendations by Year

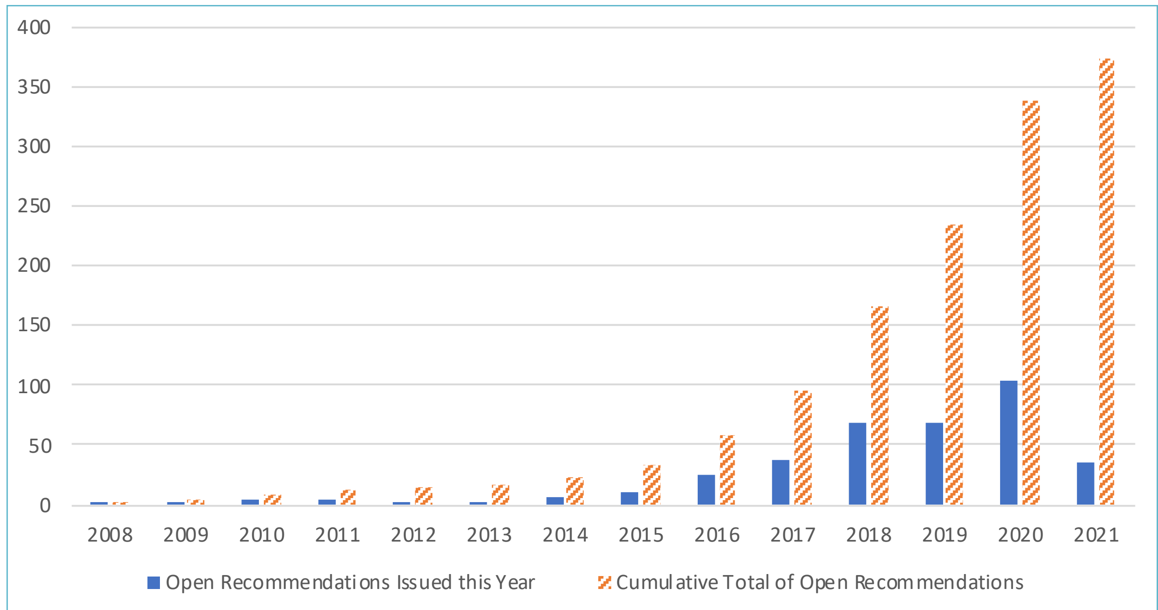


Exhibit 4: Open Internal Recommendations by Year. This multi-bar graph of recommendations made to internal entities shows the number of open recommendations issued per year and the number of cumulative open recommendations over time. The graph starts in 2008 with two recommendations, shown in both the new and cumulative bars. The number of open recommendations really begins to accumulate after about 2015, with 58 cumulative open recommendations in 2016, 96 in 2017, and 165 in 2018. The chart ends in 2021 (January through September only) with 374 cumulative recommendations open for more than six months.

On the other hand, recommendations made to external entities (such as FEHBP health insurance carriers) account for only 11 percent of recommendations open for more than six months, the oldest dating back only to 2017. This is in spite of the fact that, as seen above, recommendations made to external entities account for 69 percent of OIG recommendations issued since 2008.

To date, there are only 48 outstanding recommendations that have been open for at least six months for all external organizations. Of these, over half were issued between January 1st and September 30th of 2021.

Exhibit 5: Open External Recommendations by Year

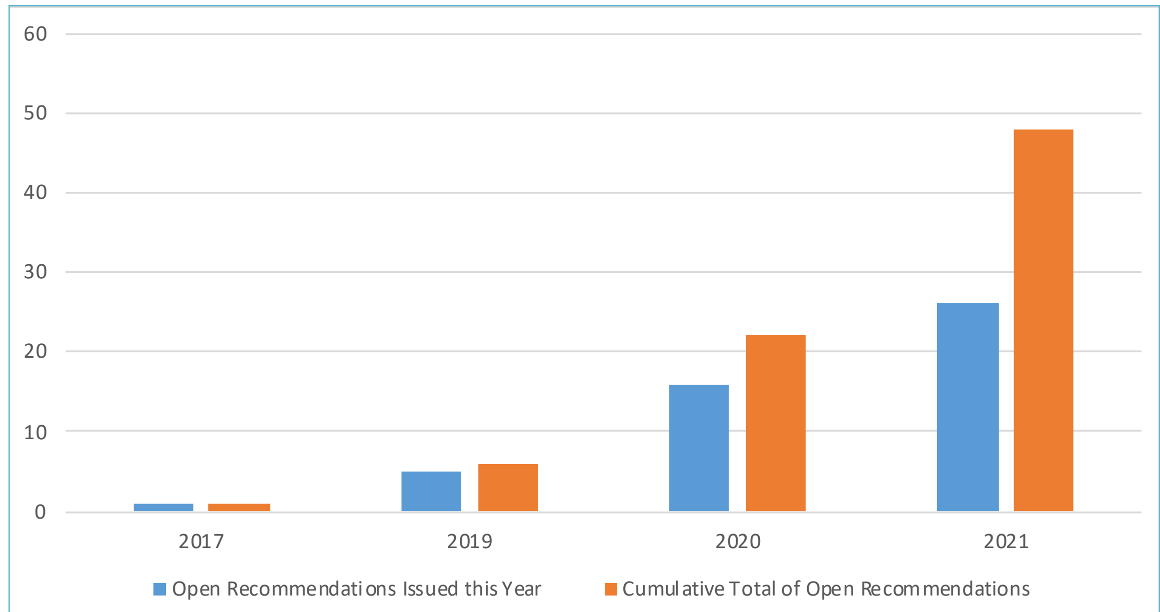


Exhibit 5: Open External Recommendations by Year. This multi-bar graph for recommendations made to external entities shows the number of open recommendations issued per year and the number of cumulative open recommendations over time. The graph starts in 2017 with one recommendation, shown in both the new and cumulative bars. The graph ends in 2021, with 26 new recommendations made between January 1st and September 30th of that year and 48 total cumulative recommendations open for more than six months.

Office of the Chief Information Officer Open Recommendations

As mentioned in our two most recent annual Top Management Challenges reports and in our most recent semiannual report to Congress, information systems recommendations make up a large portion of overall outstanding recommendations. This problem compounds over time, as new recommendations are made and old recommendations remain unaddressed. As shown in the chart below, the number of open recommendations made to the Office of the Chief Information Officer (OCIO) has increased steadily since about 2015.

Exhibit 6: Open OCIO Recommendations by Year

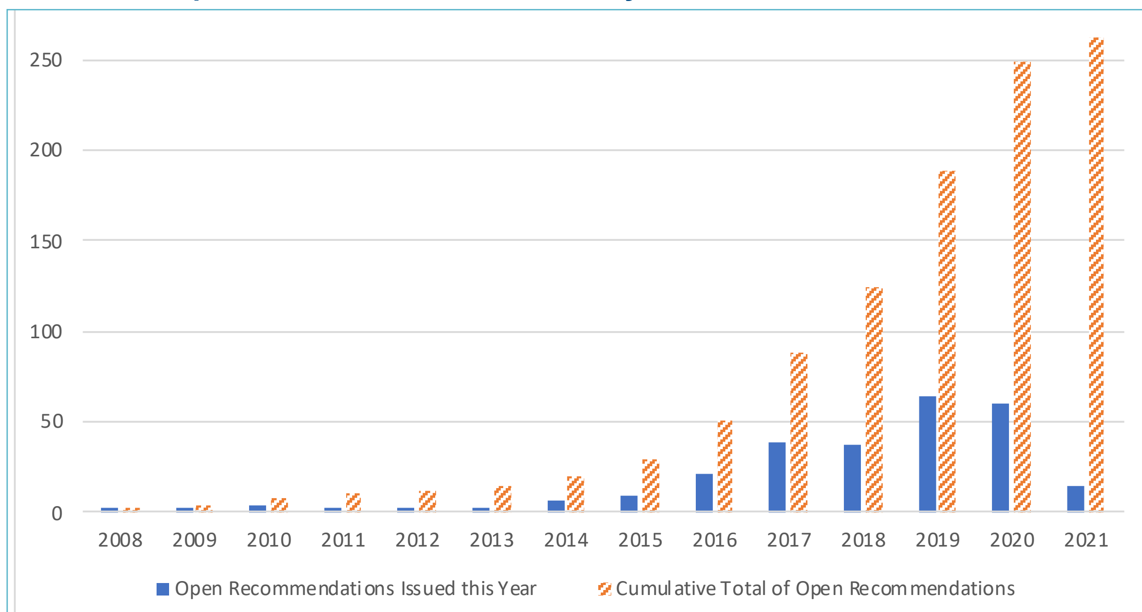


Exhibit 6: Open OCIO Recommendations by Year. This multi-bar graph for recommendations made to OPM's OCIO shows the number of open recommendations issued per year and the number of cumulative open recommendations over time. The graph starts in 2008 with two recommendations, shown in both the new and cumulative bars. The number of open recommendations substantially begins to accumulate after about 2015, with 50 cumulative open recommendations in 2016, 88 in 2017, and 125 in 2018. The chart ends in 2021 with 14 recommendations issued between January 1st and September 30th of that year and a cumulative total of 263 recommendations open more than six months.

The total count of 263 OCIO recommendations that have been open for over six months includes 126 unique recommendations. This means that 137 of these recommendations have been carried forward from a prior audit.

There are currently 17 categories of open OCIO recommendations, including those highlighted below, as well as other categories, such as access control, system and information integrity, physical and environmental protection, incident response, and inventory management. The top five categories are configuration management, security assessment and authorization, contingency planning, audit and accountability, and risk assessment.

Exhibit 7: Top Five Categories of Unique Open OCIO Recommendations

Exhibit 7: Top Five Categories of Unique Open OCIO Recommendations. This pie chart shows the top five categories of open recommendations made to OPM's OCIO. The categories are: Configuration Management (18), Security Assessment and Authorization (17), Contingency Planning (12), Audit and Accountability (11), and Risk Assessment (11).

These five categories account for 69 of the 126 unique open OCIO recommendations. As seen in the table below, recommendations have been open in some of these categories for over a decade, persisting through at least 10 acting and permanent OPM CIOs, 4 administrations, and the OPM data breach in 2015.

Exhibit 8: Top Five Categories of Unique Open OCIO Recommendations with Year First Opened and General Overview of the Oldest/Most Recurring Recommendation

Category	Number of Open Recommendations	Year First Recommended	General Overview
Configuration Management	18	2015	Develop and implement a baseline configuration for all operating platforms.
Security Assessment and Authorization	17	2016	• Adhere to remediation dates for Plan of Actions and Milestones (POA&M) weaknesses. • Update remediation deadlines if a weakness has not been addressed by the originally scheduled deadline. • Perform a security controls assessment on the LAN/WAN.
Contingency Planning	12	2008	• Test the contingency plan for each system on an annual basis.

Category	Number of Open Recommendations	Year First Recommended	General Overview
Audit and Accountability	11	2010	• Ensure that POA&Ms remain accurate and complete. • Ensure that resources are prioritized and assigned to address information system control environment weaknesses.
Risk Assessment	11	2016	• Complete risk assessments for each major information system. • Implement data-driven prioritization as a method to decide risk-based allocation of resources.

Exhibit 8: Top Five Categories of Unique Open OCIO Recommendations with Year First Opened and General Overview of the Oldest/Most Recurring Recommendation. This table lists some details about the top five categories of open OPM OCIO recommendations, including: the number of open recommendations in each category, the year the oldest outstanding recommendation in that category was made, and a general overview of types of recommendations outstanding in that category.

Examining the control weaknesses listed in this table alone provides a picture of some of the overarching issues the OCIO has had with closing OIG audit recommendations. For example, OPM has not met our recommendation to adhere to remediation dates for POA&Ms, nor has it updated the remediation dates accordingly when the original date has been exceeded. Additionally, the second recommendation examples given above under the categories "risk assessment" and "audit and accountability" are telling as well. Both recommendations highlight the fact that the OCIO has yet to successfully prioritize and assign resources accordingly. Not implementing corrective action for longstanding control weaknesses increases the risk of future IT security incidents, potentially jeopardizing the availability and reliability of OPM resources as well as the privacy and integrity of Federal employee information.

However, as we did in our last semiannual report to Congress, we would like to acknowledge the OCIO's recent renewed commitment to working towards recommendation closure. In that same semiannual report to Congress, we noted that the Chief Information Officer (CIO) had informed our office that he was placing a new focus on open recommendations and devoting resources and staff who would be tasked with closing recommendations. Since then, we have heard from the CIO that recommendation closure has been incorporated into the performance standards for OCIO Senior Executive Staff members and noted that the OCIO closed 19 recommendations in the last 6 months. We are encouraged by the CIO's sentiments and actions taken so far in his short tenure to prioritize outstanding recommendations and look forward to seeing these actualized in increased recommendation implementation and closure soon.

Also, in our last semiannual report to Congress, we urged Director Ahuja to take a similar approach with all other OPM program offices. We would like to reiterate this point, both to encourage other program offices to devote resources and staff to recommendation closure and to ensure that the OCIO continues to prioritize recommendation closure and increase follow-through with actual implementation of corrective actions.

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.

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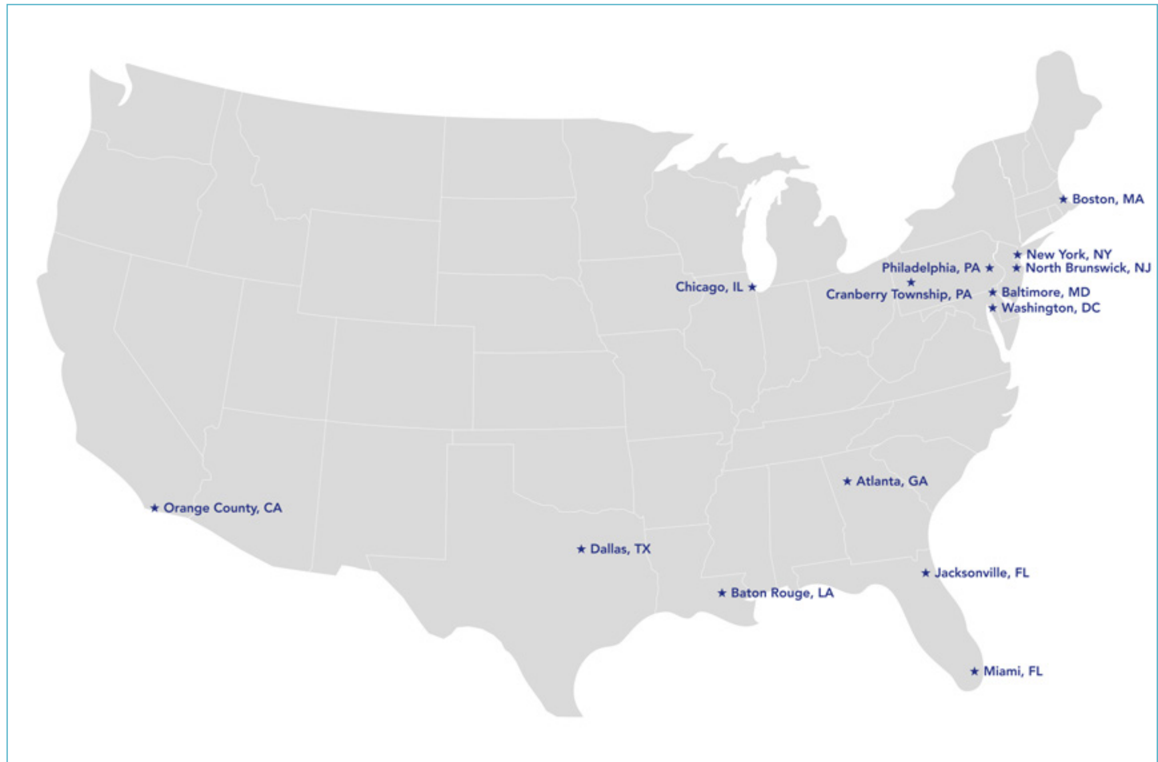
OIG Office Locations



Office Locations:

Atlanta, GA
Baltimore, MD
Baton Rouge, LA
Boston, MA
Chicago, IL
Cranberry Township, PA
Dallas, TX
Jacksonville, FL
Miami, FL
New York, NY
North Brunswick, NJ
Orange County, CA
Philadelphia, PA
Washington, DC

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.

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.

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 return of lost investment income.

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

- The medical and prescription 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 Medical Loss Ratio (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.
>
> **SSSG** is the carriers' commercial group that is numerically closest in contract size to the FEHBP.

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 rating carriers continue to be subject to the SSSG comparison rating methodology, which was amended in 2015 to require only one rather than two SSSGs.

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

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

Independent Health Association, Inc.
Buffalo, New York
Report Number 1C-QA-00-21-003
January 7, 2022

Independent Health Association, Inc. (Plan) has participated in the FEHBP since 1983 and provides health benefits to FEHBP members in the Western New York State area. The audit covered contract years 2016 through 2018. During this period, the FEHBP paid the Plan approximately $249.2 million in premiums.

Numerous errors and insufficient controls around FEHBP-specific rating and MLR processes led to questioned costs of $1.2 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 2016 through 2018. This resulted in questioned costs totaling $1.2 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 unsupported and unallowable non-claims expenses and surcharges and did not properly coordinate claims with other insurance providers in its rate developments and FEHBP MLR filings;
- Included erroneous prior year data to calculate the 2016 FEHBP MLR;
- Incorrectly reported fraud recoveries twice in the FEHBP MLR filings;
- Incorrectly calculated its taxes and regulatory fees included in the MLR filings; and
- Had insufficient internal controls that did not adequately meet the contractual criteria, especially related to dependent terminations, FEHBP MLR calculations, record retention, and complete and timely responses to the OIG.

Group Health Cooperative of South Central Wisconsin
Madison, Wisconsin
Report Number 1C-WJ-00-19-004
February 14, 2022

Group Health Cooperative of South Central Wisconsin (Plan) has participated in the FEHBP since 1979 and provides health benefits to FEHBP members in the South Central Wisconsin area. The audit covered contract years 2014 through 2016. During this period, the FEHBP paid the Plan approximately $88.8 million in premiums.

Various claim processing errors were found related to benefit configurations and cost-sharing applications.

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2016.

Specifically, we found that the Plan:

- Had various benefit configuration and cost-sharing application issues with processing medical claims in contract year 2016;
- Did not properly calculate the non-income tax fees reported on its MLR submissions; and
- Did not maintain documentation to support the data in the fraud, waste, and abuse reports submitted to OPM.

Experience-Rated Carriers

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

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

During the current reporting period, we issued four final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP. These four final audit reports contained recommendations for the return of over $2 million to the OPM-administered trust fund.

Blue Cross Blue Shield Service Benefit Plan Audits

The BlueCross BlueShield Association (BCBS Association), on behalf of 60 participating plans offered by 34 BCBS companies, has entered into a governmentwide Service Benefit Plan (SBP) 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 SBP.

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management of the SBP. 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 SBP Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary for claims processing 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 are summaries of three recent BCBS audits that are representative of our work.

Highmark Health
Pittsburgh, Pennsylvania
Report Number 1A-10-13-21-006
November 15, 2021

Our multi-plan company audit of the FEHBP operations at Highmark Health (the Plan) covered miscellaneous health benefit payments and credits (such as refunds and medical drug rebates) and administrative expense charges pertaining to the BlueCross and/or BlueShield plans of Delaware, Pennsylvania, Northeastern Pennsylvania, and West Virginia. We also reviewed Highmark Health's cash management activities and practices related to FEHBP funds and the Plan's fraud and abuse program activities.

We questioned $820,767 in health benefit charges, net administrative expense overcharges, and lost investment income. Our most significant findings were that Highmark Health overcharged the FEHBP $340,670 for BCBS Association dues and $246,534 (net) for post-retirement benefit costs. The BCBS Association and Highmark Health agreed with all of the questioned amounts. As part of our review, we verified that Highmark Health subsequently returned $745,419 of these questioned amounts to the FEHBP. As of the time of this semiannual report to Congress, one monetary recommendation remains open for questioned charges of $63,891.

The audit disclosed no findings pertaining to Highmark Health's cash management activities and practices related to FEHBP funds or the Plan's fraud and abuse program activities. Overall, we determined that Highmark Health handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and Federal regulations. We also determined that the Plan complied with the communication and reporting requirements for fraud and abuse cases to the OIG.

Arkansas BlueCross BlueShield
Little Rock, Arkansas
Report Number 1A-10-44-21-001
December 6, 2021

Our audit of the FEHBP operations at Arkansas BCBS covered the plan's miscellaneous health benefit payments and credits, administrative expense charges, cash management activities and practices, and fraud and abuse program activities. We questioned $114,439 in health benefit refunds, net administrative expense overcharges, cash management activities, and lost investment income. Our most significant finding was that Arkansas BCBS had not returned eight health benefit refunds, totaling $75,469, to the FEHBP.

The BCBS Association and Arkansas BCBS agreed with all of the questioned amounts. As part of our review, we verified that Arkansas BCBS subsequently returned these questioned amounts to the FEHBP.

Audit of Claims Processing and Payment Operations at Health Care Service Corporation
Washington, D.C.
Report Number 1A-10-17-21-018
Original Issue Date: February 23, 2022
Corrected Report Issue Date: March 16, 2022

Our audit of the FEHBP claims processing and payment operations at Health Care Service Corporation (Plan) was performed to determine if the Plan's internal controls over its claims processing system were sufficient to ensure the proper processing and payment of health care claims. We identified 2,175 improperly paid claims resulting in net FEHBP overpayments of $982,117. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Claims with unlisted procedure codes;
- Claims requiring coordination of benefits with Medicare;
- Potential duplicate claim payments;
- Provider network status determinations; and
- Co-surgeon claims.

This final report included 2 monetary and 16 procedural recommendations. The BCBS Association agreed with 13 of the 18 recommendations and has already returned $315,718 of the overpayments to the FEHBP, leaving $868,997 still owed to the FEHBP and $202,598 in underpayments owed to the Plan. All the recommendations remain open.

Global Audits

Global audits of BCBS plans are crosscutting reviews of specific issues we determine are likely to cause improper payments. These audits cover all 60 BCBS plans offered by the 34 participating BCBS companies.

We issued one global audit report related to experience-rated health plans during this reporting period.

Audit of Coordination of Benefits with Medicare
at Select Blue Cross and Blue Shield Plans
Washington, D.C.
Report Number 1A-99-00-21-019
January 3, 2022

Our global coordination of benefits (COB) audit at select BCBS plans was performed to determine whether the selected plans complied with contractual provisions relative to COB with Medicare.

Our audit identified 80 claim lines totaling $107,108 in FEHBP overcharges. The overcharges resulted from retroactive Medicare enrollment information that was added to the plans' claims processing systems after the claim lines were initially processed. The addition of this information resulted in needed adjustments to these claim lines. Additionally, of the 80 claim lines, we identified 23 (29 percent) where the select BCBS plans did not initiate recoveries of the overpayments until 91 or more days after the updated Medicare information was available in their claims processing systems. In fact, 15 of these 23 claim lines did not have recoveries initiated until more than 1 year after the updated information was available. Delays of this length could jeopardize the recovery process because claims received by Medicare more than 1 calendar year after the date of service could be denied due to being outside of its timely filing requirements.

This final report included one monetary and one procedural recommendation. The BCBS Association agreed with both recommendations, returning a total of $101,025 to the FEHBP. The remaining $6,083 was written off as uncollectible. The procedural recommendation remains open.

Employee Organization Plans

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

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

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

Experience-Rated Comprehensive Medical Plans

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

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

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 governmentwide 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 62 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.

Federal Information Security Modernization Act Audit for Fiscal Year 2021
Washington, D.C.
Report Number 4A-CI-00-21-012
October 27, 2021

The fiscal year (FY) 2021 Federal Information Security Modernization Act (FISMA) Inspector General reporting metrics use a maturity model evaluation system derived from the National Institute of Standards and Technology's Cybersecurity Framework. The Cybersecurity Framework is comprised of nine "domain" areas and the weighted averages of the domain scores are used to derive the agency's overall cybersecurity score. In FY 2021, OPM's cybersecurity maturity level was measured as "2 – Defined."

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

Risk Management – OPM has defined an enterprise-wide risk management strategy through its risk management council. OPM is working to implement a comprehensive inventory management process for its hardware and software inventory.

Supply Chain Risk Management – OPM's Supply Chain Risk Management program is ad hoc and needs to be developed.

Configuration Management – OPM continues to develop baseline configurations and approve standard configuration settings for its information systems. The agency has an established configuration change control process.

Identity, Credential, and Access Management (ICAM) – OPM is continuing to develop its agency ICAM strategy. OPM has enforced multifactor authentication with Personal Identity Verification cards.

Data Protection and Privacy – OPM has defined controls related to data protection and privacy including data exfiltration prevention. However, OPM's role-based privacy training beyond the existing privacy awareness training still needs to be developed.

Security Training – OPM has implemented a security training strategy and program. OPM has performed a workforce assessment but is still working to address gaps identified in its security training needs.

Information Security Continuous Monitoring – OPM has established many of the policies and procedures surrounding continuous monitoring, but the agency has not completed the implementation and enforcement of the policies. OPM also needs to continue to improve with conducting security controls assessments on all of its information systems.

Incident Response – OPM has implemented many of the required controls for incident response. Based upon our audit work, OPM has successfully implemented all of the FISMA metrics at the level of Consistently Implemented or higher.

Contingency Planning – OPM has not implemented several of the FISMA requirements related to contingency planning but continues to improve upon maintaining its contingency plans as well as conducting contingency plan tests on a routine basis.

Audit of the Information Systems General and Application Controls at CVS Caremark
Scottsdale, Arizona
Report Number 1H-01-00-21-022
March 16, 2022

CVS Caremark (CVS) is the pharmacy benefit manager responsible for processing prescription drug claims on behalf of several insurance carriers that contract with OPM as part of the FEHBP. Our IT audit focused on the claims processing applications used to adjudicate pharmacy claims for FEHBP members, as well as the various processes and IT systems used to support these applications. Our audit of the IT security controls of CVS determined that:

- An adequate security management program is implemented;
- Adequate physical and logical access controls are in place;
- Vulnerabilities discovered as a result of the vulnerability scan exercise require remediation;
- The enterprise security event monitoring and incident response programs are adequate;
- The contingency planning program is adequate; and
- CVS has adequate application change control policies and procedures.

Audit of the Information Systems General and Application Controls At EmblemHealth
New York, New York
Report Number 1D-80-00-21-025
March 21, 2022

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

- EmblemHealth has established adequate security management controls including IT security policies and procedures and risk management. Segregation of duty risk assessments have not been performed for provisioned entitlements;
- EmblemHealth has adequate physical and logical access control;
- EmblemHealth does not have adequate controls in place related to user-installed software. Additionally, our vulnerability and compliance scan exercise identified some technical weaknesses in EmblemHealth's network environment;
- EmblemHealth has adequate incident response procedures. However, EmblemHealth does not have database security event monitoring controls in place;
- EmblemHealth does not conduct routine security configuration audits. Additionally, we identified instances of unsupported software in EmblemHealth's network environment;
- EmblemHealth has adequate controls over contingency planning; and
- EmblemHealth has adequate controls over its application change control process.

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 internal auditing 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 Data Submission and Compliance with the Digital Accountability and Transparency Act of 2014
Washington, D.C.
Report Number 4A-CF-00-20-044
November 8, 2021

The Digital Accountability and Transparency Act of 2014 (DATA Act) was enacted on May 9, 2014, to expand the reporting requirements pursuant to the Federal Funding Accountability and Transparency Act of 2006. The DATA Act requires Federal agencies to report financial and award data in accordance with established governmentwide financial data standards. In May 2015, the U.S. Office of Management and Budget (OMB) and the U.S. Department of the Treasury (Treasury) published 57 data definition standards (referred to as data elements) and required Federal agencies to report financial and award data in accordance with these standards for DATA Act reporting, starting in January 2017. Beginning in May 2017, in accordance with the DATA Act, Treasury began displaying Federal agencies' data on USAspending.gov so that taxpayers and policymakers could review and use the information.

In April 2020, OMB issued M-20-21, *Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019* (COVID-19), which made changes to DATA Act reporting, including that two additional data elements, significant in promoting the full and transparent reporting for COVID-19 spending, would be tested under the DATA Act, resulting in a total of 59 applicable data elements to be tested during the fiscal year (FY) 2021 DATA Act audit.

The objectives of our audit were to assess (1) the completeness, accuracy, timeliness, and quality of FY 2020, fourth quarter, financial and award data submitted for publication on USAspending.gov and (2) OPM's implementation and use of the governmentwide financial data standards established by OMB and Treasury.

We found that:

- OPM has implemented and is using the governmentwide financial data standards for award and spending information as defined by OMB and Treasury;
- OPM's DATA Act submission of Files A, B, and C to the Treasury's DATA Act Broker was complete and submitted timely, with no data limitation disclosures; and

- OPM scored a quality score rating of 73 out of 100 points, which is a quality rating of Moderate, as defined by the Council of the Inspectors General on Integrity and Efficiency (CIGIE) Federal Audit Executive Council December 2020 compliance guide. Quality represents data that is complete, accurate, and reported on a timely basis.

In addition, we identified one area where OPM needs to strengthen controls over its DATA Act submission process to ensure that no discrepancies exist in the linkages between Files C and D1. While we generally found that the required elements were present in data files A, B, and C, and all 23 COVID-19 outlays tested were properly reported in File C, we determined that 113 out of the 150 non-COVID-19 transactions tested were identified in File C (award financial) and not in File D1 (award procurement).

OPM concurred with our findings. Two recommendations have been closed, and the third is resolved per development of OPM's planned corrective action.

OPM's Consolidated Financial Statements Audits

The Chief Financial Officers Act of 1990 (Public Law 101–576) requires OPM's Inspector General or an independent external auditor, as determined by the Inspector General, to audit the agency's financial statements in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. OPM contracted with Grant Thornton LLP, an independent certified public accounting firm, to audit the consolidated financial statements as of September 30, 2021, and September 30, 2020. The contract required that the audit be performed in accordance with generally accepted government auditing standards (GAGAS) and OMB Bulletin No. 21-04, *Audit Requirements for Federal Financial Statements.*

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

Grant Thornton was responsible for, but was not limited to, issuing an audit report that included:

- Opinions on the consolidated financial statements and the individual statements for the three benefit programs;

- A report on internal controls; and

- A report on compliance with certain laws and regulations.

In connection with the audit contract, we reviewed Grant Thornton's report and related documentation and made inquiries of its representatives regarding the audit. To fulfill our audit responsibilities under the Chief Financial Officers Act for ensuring the quality of the audit work performed, we conducted a review of Grant Thornton's audit of OPM's Fiscal Year 2021 Consolidated Financial Statements in accordance with *Government Auditing Standards*. Specifically, we:

- Provided oversight of—and technical advice and general liaison services to—Grant Thornton auditors;

- Ensured that audits and audit reports were completed timely and in accordance with the requirements of GAGAS, OMB Bulletin 21-04, and other applicable professional auditing standards;
- Documented oversight activities and monitored audit status;
- Reviewed responses to audit reports and reported any significant disagreements to the audit follow-up official per OMB Circular No. A-50, Audit Follow-up
- Coordinated issuance of the audit report; and
- Performed other procedures we deemed necessary.

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

OPM's FY 2021 Consolidated Financial Statements
Washington, D.C.
Report Number 4A-CF-00-21-027
November 12, 2021

Grant Thornton audited OPM's financial statements, which comprise the following:

- The consolidated balance sheets as of September 30, 2021, and 2020;
- The related consolidated statements of net cost, changes in net position, and the combined statements of budgetary resources for the years then ended;
- The related notes to the consolidated financial statements;
- The individual balance sheets of the Retirement, Health Benefits, and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2021, and September 30, 2020;
- The related individual financial statements of net cost, changes in net position, and budgetary resources for the years then ended; and
- The related notes to the individual financial statements.

Grant Thornton reported that OPM's consolidated financial statements and the Programs' individual financial statements as of and for the FYs ended September 30, 2021, and September 30, 2020, were presented fairly in all material respects, and in conformity with U.S. Generally Accepted Accounting Principles. Grant Thornton's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

Grant Thornton identified one material weakness in the internal controls related to OPM's information systems control environment. However, they did not identify any significant deficiencies.

Information Systems Control Environment continues to be a material weakness in FY 2021.

Information Systems Control Environment: During FY 2021, deficiencies noted in FY 2020 continued to exist, and Grant Thornton's testing identified similar control issues in both the design and operation of key controls. Grant Thornton believes that, in many cases, these deficiencies continue to exist because of one, or a combination, of the following:

- Oversight and governance are insufficient to enforce policies and address deficiencies;
- Risk mitigation strategies and related control enhancements require additional time to be fully implemented or to effectuate throughout the environment; and
- Dedicated budgetary resources are required to modernize OPM's legacy applications.

The information system issues identified in FY 2021 included repetitive conditions consistent with prior years, as well as new deficiencies. The deficiencies in OPM's information systems control environment are in the areas of Security Management, Logical Access, Configuration Management and Interface / Data Transmission Controls. In the aggregate, these deficiencies are considered to be a material weakness. OPM concurred with the findings and recommendations reported by Grant Thornton.

Grant Thornton's report identified instances of noncompliance with the Federal Financial Management Improvement Act of 1996 (FFMIA) Section 803(a), as described in the material weakness, in which OPM's financial management systems did not substantially comply with the Federal financial management systems requirements. The results of Grant Thornton's tests of FFMIA Section 803(a) disclosed no instances of substantial noncompliance with the applicable Federal accounting standards and the application of the U.S. Government Standard General Ledger at the transaction level.

OPM's Utilization of the Improper Payments Do Not Pay Initiative
Washington, D.C.
Report Number 4A-CF-00-20-029
February 14, 2022

Our auditors completed a performance audit of OPM's utilization of the improper payments Do Not Pay (DNP) Initiative.

The Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA) established the DNP Initiative. The Federal Improper Payments Coordination Act of 2015 expanded the IPERIA authority for the legislative and judicial branches to use the DNP Initiative, including Treasury's DNP Business Center, for the purpose of verifying payment or award eligibility for payment. Treasury's Bureau of the Fiscal Service operates the DNP Business Center, which provides tools, such as the DNP Portal, data analytics services, and support to Federal and State government agencies in the identification, detection, and prevention of improper payments under IPERIA.

Additionally, the Payment Integrity Information Act of 2019 directs each executive agency to review prepayment and pre-award procedures and ensure that a thorough review of available databases, with relevant information on eligibility, occurs to determine program or award eligibility and prevent improper payments before the release of any Federal funds.

The objective of our audit was to determine if OPM's Retirement Services, Office of the Chief Financial Officer (OCFO), Healthcare and Insurance, and Office of Procurement Operations (OPO) programs have access to and are utilizing the appropriate DNP data sources and tools that are available to help minimize and prevent improper payments.

We determined that Retirement Services, OCFO, and OPO are utilizing the DNP Portal and data sources. Specifically:

- Retirement Services uses the DNP Portal to match annuitant payments to death data sources, such as the Death Master File;
- The OCFO uses Treasury's Offset Program Debt Check, which collects past-due debts owed to State and Federal agencies for payroll; and
- The OPO uses the System for Award Management (SAM) to determine if merchants or vendors appear on the SAM Registration list but not on the SAM Exclusions list at the time of the payment or contract for purchase cards and vendor contracts.

However, we also determined that:

- Retirement Services paid three deceased annuitants, out of 197 sampled, a total of $421,040 in potential improper payments;
- Retirement Services' internal controls did not include a supervisory level review over Treasury's monthly DNP report, entitled *Do Not Pay Match Results for Payment*;
- Healthcare and Insurance had not been using the DNP Portal for new carrier applicants since 2017; and
- As a best practice, OPM should continue to maintain an active relationship with the DNP Business Center to make the most of their analytic services and new data sources continually being added in the DNP Portal.

Special Audits

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

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

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

The following summary highlights the results of two audits conducted by the Special Audits Group during this reporting period.

Audit of the Hawaii Medical Service Association's
Federal Employees Health Benefits Program
Pharmacy Operations as Administered by Caremark
Jacksonville, Florida and Cranberry Township, Pennsylvania
Report Number 1H-02-00-20-033
November 15, 2021

We completed a performance audit of the Hawaii Medical Service Association's (the Carrier) FEHBP pharmacy operations as administered by Caremark (the PBM). Our audit consisted of a review of the administrative fees, annual accounting statements, claims pricing and eligibility, drug manufacturer rebates, fraud and abuse program, and performance guarantees for pharmacy operations from contract years 2016 through 2019.

We determined that the PBM and the Carrier need to strengthen their procedures and controls related to prescription drug pricing and termination of ineligible dependents. Specifically, our audit identified the following deficiencies that require corrective action:

- The PBM overcharged the FEHBP $2,327,880 (including lost investment income) by not providing pass-through transparent pricing based on the actual acquisition cost of drugs filled by its mail-order warehouses and specialty pharmacies from 2016 through 2019;
- The Carrier overcharged the FEHBP $2,508,534 (including lost investment income) by not returning the 2016 retail generic drug pricing guarantees that were paid by the PBM to the Carrier; and
- The Carrier failed to properly terminate ineligible dependents after their 26th birthday in cases where a premium change was needed, resulting in prescription drug overcharges of $6,808 (including lost investment income) for 2019.

No other exceptions were identified from our reviews of the administrative fees, annual accounting statements, drug manufacturer rebates, fraud and abuse program, and performance guarantees.

Caremark overcharged the Carrier on the price for drugs filled by its own mail order warehouses and specialty pharmacies.

Audit of BENEFEDS as Administered by Long Term Care Partners, LLC (dba FedPoint)
Cranberry Township, Pennsylvania
Report Number 1G-FP-00-21-004
December 6, 2021

As mentioned above, OPM administers insurance and retirement benefits for millions of Federal employees, annuitants, and their dependents. As part of its mission to manage insurance benefits, OPM oversees the BENEFEDS program, a web-based portal that currently handles enrollment and premium administration services for FEDVIP and FLTCIP, plus payroll allotment services for FSAFEDS. BENEFEDS was implemented in 2006. The four major components to BENEFEDS include a 24/7 enrollment website (www.BENEFEDS.com), data transmissions to and from the insurance carriers, a premium administration system, and a customer service system.

We completed a performance audit of BENEFEDS as administered by Long Term Care Partners, LLC (doing business as FedPoint). Our audit included a review of the administrative expenses, cash management, coordination of benefits, enrollment, fraud and abuse program, and performance standards for BENEFEDS operations during contract years (CY) 2017 through 2019.

We found that Long Term Care Partners properly administered BENEFEDS operations from CYs 2017 through 2019. There were no audit findings related to our review of the administrative expenses, cash management, coordination of benefits, enrollment, fraud and abuse program, and performance standards for BENEFEDS operations. As a result, we determined that the costs charged to BENEFEDS and services provided to its users were in accordance with the terms of the Contract and applicable Federal regulations.

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 to OPM program beneficiaries, the substantial loss of taxpayer dollars, or agency program weaknesses that allow fraud, waste, and abuse.

In this semiannual report to Congress, we present selected summaries that are representative of our investigative efforts to protect OPM beneficiaries, programs, and operations from fraud, waste, abuse, or mismanagement.

We also take this opportunity to highlight operational challenges currently affecting our investigative operations. One of the ongoing challenges for the Office of Investigations is the continued exclusion of the FEHBP from the Anti-Kickback Statute. This exclusion can interfere with our ability to protect the FEHBP and its members from improper conduct that, when committed against any other Federally funded health care program, constitutes a Federal crime. Improperly paid FEHBP dollars can go unrecovered because of our exclusion. The Anti-Kickback Statute continues to preclude the FEHBP from recovering funds on common types of health care fraud criminal investigations and civil settlements. This same exclusion will apply to the new Postal Service Health Benefits Program (PSHBP), which will be set up as a subprogram under the FEHBP because of the recent Postal Service Reform Act.[13]

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.

[13] The Legal and Legislative Activities section of this report has more information about the PSHBP and the Postal Service Reform Act's effects.

FEHBP Health Care Fraud Investigations

Our Office of Investigations pursues criminal, civil, and administrative investigations into fraud, waste, or abuse that affects the FEHBP.

Health care fraud is complex and costly. In a rapidly changing health care environment—complicated by the COVID-19 pandemic, the opioid crisis, and other fraud trends—we continue our work against health care fraud schemes that are sophisticated, disruptive, and harmful.

FEHBP investigations are the majority of our investigative caseload. These investigations protect FEHBP enrollees from patient harm and protect the program's financial integrity. Bad actors who prioritize dollars over patient care can victimize patients, and unchecked fraud, waste, and abuse increases FEHBP costs—which are passed on to FEHBP enrollees and taxpayers.

In this semiannual report, we highlight our oversight of the FEHBP through:

- Summaries of investigative activities involving traditional health care fraud schemes that continue to affect the FEHBP; and
- Summaries of cases highlighting our ongoing work to protect FEHBP members and their families from the harms of opioid and substance abuse, including investigations of drug manufacturers and sober homes.

Summaries of Select FEHBP Health Care Investigations

The FEHBP is the largest employer-sponsored health program in the world, and one of the most important and significant benefits provided to Federal employees and their families. However, the program is vulnerable to much of the same fraud, waste, and abuse as the general health care environment. It also has vulnerabilities unique to its nature as a Government health care program wherein a network of private health insurers contract with OPM to provide health insurance benefits.

Below, we detail some of our work to protect the FEHBP and its enrollees.

We also provide an update on a case involving an employee who worked for an FEHBP health insurance carrier's Special Investigations Unit (SIU). An SIU is a health insurance carrier's internal group that provides liaison and investigative support to the OIG about allegations fraud, waste, or abuse that harm the FEHBP through the contracted carrier. While our enforcement strategy leverages the reach of our SIU partners to protect their FEHBP health insurance carriers at the local level, we provide the top-level oversight of the FEHBP. Therefore, we must be able to trust FEHBP health insurance carrier SIUs to operate as partners in our investigations into FEHBP fraud, waste, and abuse.

Case Update: FEHBP Health Insurance Carrier Employee Sentenced for Role in Health Care Fraud

In our previous semiannual report to Congress (April 1, 2021–September 30, 2021), we detailed a significant case involving health care fraud by a group of medical spas billing cosmetic services as medical procedures. As part of this case, we identified that an employee in the SIU of an FEHBP health insurance carrier provided help in allowing co-conspirators to continue their fraud scheme.

The SIU investigator supplied billing codes that allowed the fraudsters to avoid detection. These billing codes were able to be processed by FEHBP carriers as legitimate claims and obscured the ongoing fraud. The illegal help even included closing the health insurance carrier's SIU investigations into the spas to protect the fraud scheme.

During our investigation, the SIU investigator was removed from their position. The FEHBP health insurance carrier fully cooperated with our investigation.

On November 29, 2021, the SIU investigator was sentenced to 18 months of imprisonment by the U.S. District Court for the Central District of California.

Fraud by employees of contracted FEHBP health insurance carriers is a serious risk to the integrity and structure of the FEHBP. We will continue our oversight of FEHBP-contracted health insurance carriers to stop fraud, waste, and abuse that harms the FEHBP.

Twenty Individuals at Physical Therapy Practice Indicted on Health Care Fraud Charges

In December 2020, we received a *qui tam* lawsuit filed in the U.S. District Court for the Western District of Pennsylvania that alleged a physical therapy provider group improperly billed Government health care programs for its services. Specifically, services billed as if provided by a licensed physical therapist were performed by unlicensed and untrained physical therapist assistants. Additionally, the provider allegedly billed for more working hours than possible.

Our investigative analysts found that the FEHBP had paid $209,242 to the physical therapy provider group between 2016 and 2021.

The physical therapy provider group was indicted in the U.S. District Court for the Western District of Pennsylvania on November 9, 2021. The indictment charged the physical therapy provider group with health care fraud and conspiracy to commit wire and health care fraud.

According to the indictment presented to the court, unlicensed technicians provided treatment and billed as if licensed; used the treatment documentation system to facilitate the fraud; billed for treatment time in excess of actual time that was spent with patients; did not appropriately use group codes; used the credentials of a licensed physical therapist who was on vacation and not working; covered up who actually treated patients by removing the names of the provider from the treatment record; and manually changed patient schedule information to conceal details of the fraud.

Twenty individuals have been indicted for allegations related to the actions of this physical therapy practice.

In total, 20 individuals were named in the indictment. The case is ongoing, and as a reminder: an indictment is an accusation. All defendants are presumed innocent unless and until proven guilty.

More information about this case is available from the U.S. Department of Justice (DOJ): https://www.justice.gov/usao-wdpa/pr/hertel-brown-physical-aquatic-therapy-its-two-founders-aaron-hertel-and-michael-brown.

Special Health Care Fraud Topic: The Ongoing Opioid and Substance Abuse Crisis

The opioid epidemic has been recognized as a Public Health Emergency in the United States since October 2017. While illicitly manufactured synthetic opioids (like fentanyl) are driving current trends in overdose and addiction deaths, prescription opioid abuse and abuse in the treatment and recovery of opioid addiction is still a concern.

Investigations of opioid and substance abuse-related fraud, waste, and abuse are a priority for our Office of Investigations, especially opioid-related cases with allegations of or increased risk for patient harm.

Recovery and care for those with opioid addiction and risk of overdose are also concerning areas where we continue to see fraud, waste, and abuse. Our ongoing efforts to protect FEHBP beneficiaries from predatory sober homes and recovery centers is a major focus of our investigations. We have also investigated fraud involving a manufacturer of opiate antagonists used to treat opioid overdose.

In this semiannual report to Congress, we highlight the following investigative successes in cases involving opioids and other drugs of abuse:

Medical Provider Pleads Guilty to Inappropriately Prescribing Fentanyl

In May 2017, we were contacted by a Federal law enforcement partner about a medical practice under investigation for prescribing large quantities of prescription narcotics, including a fentanyl-based opioid, Subsys.

Our investigation found that the medical provider at the practice received kickbacks when they prescribed Subsys to patients who did not meet the medical criteria to receive the medication. The FEHBP had paid $639,981 for Subsys prescriptions written by this provider.

Allegedly, a company paid this provider $140,000 over 2 years to prescribe Subsys to patients who did not meet the medical criteria. A U.S. Attorney involved in the case was quoted as saying that the medical provider prescribed these medications "while knowing that such illegal practices could result in overdoses, dependence, addiction, and, in at least one case, death."

In September 2020, the medical provider was indicted in the U.S. District Court for the Middle District of Pennsylvania.

On December 6, 2021, the medical provider pled guilty to charges related to the unlawful distribution of controlled substances, maintaining drug-involved premises, and health care fraud scheme. Further judicial action related to sentencing is expected in this case.

More information on this case is available from the DOJ: https://www.justice.gov/usao-mdpa/pr/scranton-doctor-pleads-guilty-unlawfully-prescribing-controlled-substances-and-health.

Naloxone Manufacturer Agrees to $12.7 Million Settlement Because of False Claims

We received a *qui tam* lawsuit in July 2018 that alleged that a pharmaceutical manufacturer engaged in illegal activities related to an injectable naloxone medication. Naloxone is a medication used to reverse opioid overdoses.

The manufacturer of this naloxone medication allegedly devised a plan to order the medication for patients at low risk of overdose and in quantities that exceeded prescribing guidelines and patient need.

This scheme relied on a network of pharmacies that provided false statements and documents to handle preauthorization and coverage determinations for the at-issue medication. The pharmaceutical manufacturer also made no attempt to collect copayment obligations from Government beneficiaries.

The FEHBP paid $4.5 million from the launch of the medication in July 2014 until June 2019.

On November 9, 2021, the pharmaceutical manufacturer entered into a civil settlement to resolve the false claims allegations. The pharmaceutical manufacturer paid $12.7 million, of which the FEHBP received $588,873. Because this case originated as a *qui tam*, the individual who filed the case on behalf of the United States will receive $2.5 million.

More information about this case is available from the DOJ: **https://www.justice.gov/opa/pr/kal-o-inc-agrees-pay-127-million-resolve-allegations-false-claims-anti-overdose-drug**.

Indictments in Cases to Combat Addiction Treatment Kickback Schemes in Southern California

Since March 2020, we have worked with the DOJ and other Federal and State law enforcement partners on cases in the DOJ's Sober Homes Initiative. The Sober Homes Initiative is part of the DOJ's Health Care Fraud Unit's Los Angeles Strike Force.

On December 16, 2021, the DOJ released information about 10 individuals criminally charged for fraud schemes at substance abuse treatment facilities in Orange County, California.

These individuals are substance abuse facility owners and patient recruiters allegedly involved in the "body brokering" process of paying kickbacks for patient referrals to substance abuse treatment facilities, recovery homes, and laboratories. Recruiters received recurring payments for each month patients continued to receive (purported) services from the facilities. Allegedly, facility owners even assigned a value to patients depending on the patient's insurance type.

Facility owners allegedly assigned values to patients depending on the patient's insurance type as part of this "body brokering" scheme.

The indictments detail allegations of health care fraud, money laundering, paying and receiving kickbacks, and other crimes. This case is ongoing and a priority investigation for the Office of Investigations because of the involvement of sober homes and recovery facilities, as well as its potential for patient harm. More information about these indictments is available from the DOJ: **https://www.justice.gov/opa/pr/justice-department-announces-series-cases-combat-addiction-treatment-kickback-schemes**.

We look forward to sharing further details about our involvement and results when additional facts about the investigations can become public without affecting ongoing cases or judicial proceedings.

An indictment is merely an allegation. All defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Fraud, Waste, and Abuse Investigations Involving OPM Retirement Programs

In fiscal year 2021, OPM reported that its retirement programs paid $319.81 million in improper payments.

Our investigations involving OPM retirement programs most often involve the CSRS and FERS programs. However, other programs such as OPM Disability Retirement are also susceptible to improper payments and fraud, waste, or abuse.

Many of our cases involve annuitant deaths that are not reported to OPM. These cases may involve identity theft. This includes individuals forging Address Verification Letters or other documents used by OPM to verify the status of annuitants.

Representative payees or conservators are sometimes subjects in our retirement fraud investigations. These cases are particularly unfortunate because they are an abuse of the trust OPM places in individuals to act in the wellbeing of OPM annuitants.

As part of our ongoing investigative activities, we proactively conduct data projects to find money OPM pays to deceased annuitants. When we share information related to these cases with the OPM Retirement Services program office, the agency can pursue administrative actions to recover improper payments.

Regardless of the type of scheme or how it is discovered, one of the biggest issues affecting retirement-related fraud, waste, and abuse is the long durations of improper payments. Frequently, our investigations uncover years—and sometimes more than a decade—of improper payments. Our investigative activities are important in stopping these improper payments and contributing to the prosecution of those who defraud the Government or harm OPM annuitants.

Conservator Pleads Guilty to 31-Year Theft of Civil Service Retirement and Disability Fund Payments

In September 2018, a Federal law enforcement partner contacted us about potential fraud involving money paid to the disabled daughter of a deceased Federal employee.

For more than 31 years, the conservator took the Civil Service Retirement and Disability Fund payments for their use after the death of the Federal employee's daughter.

The daughter had been receiving an annuity from OPM's Civil Service Retirement and Disability Fund (CSRDF) since her mother's death in 1967. The daughter died in March 1987. Payments from OPM, however, continued until October 2018.

For more than 31 years, the conservator for the daughter—who was the niece of the Federal employee—stole the CSRDF payments. In all, OPM paid out $142,002 after the daughter's death.

In November 2021, the niece who acted as conservator was charged by criminal information in the U.S. District Court for the Eastern District of Michigan with theft of Government funds. On January 19, 2022, she pled guilty to the theft of Government funds. Sentencing is still pending, but as part of the plea agreement, the niece will make full restitution of $142,002 to OPM.

Individual Pleads Guilty to Stealing $27,903 in Post-Death Annuity Payments

In January 2020, we received a case referral from a Federal law enforcement partner about potential fraud involving the theft or improper use of a FERS annuity. Our investigation found that OPM did not stop making annuity payments to the account of a retired Federal employee who had died in 2014. The death was not reported to OPM.

Our investigation found that the deceased annuitant's son had been using the post-death annuity payments. The annuitant's son stole $27,903 in annuity payments made by OPM. OPM also continued to make payments for the deceased annuitant's health insurance premiums. This cost the program an additional $47,228. In all, OPM paid $75,131 in improper payments.

The case was accepted for prosecution in the U.S. District Court for the Western District of Virginia. On October 4, 2021, the deceased annuitant's son pled guilty to one count of theft of Government funds. On March 10, 2022, the deceased annuitant's son was sentenced by the court to 4 months of incarceration and 4 months of home confinement, followed by 1 year of supervised release. The court also ordered restitution of $87,492, of which $27,903 is owed to OPM.

Brother-In-Law Pleads Guilty to Theft of OPM Annuity

Our investigation began in January 2020 when we received information from the OPM Retirement Services program office about a CSRS annuity for a survivor annuitant who had died in September 2013 but continued to receive payments until April 2019. In an interview with investigators, the deceased's brother-in-law admitted to using the survivor annuity payments to pay off credit card bills.

OPM made payments to the account of the deceased survivor annuitant totaling $50,950. Through Treasury's reclamation process, OPM was able to recover $7,763.

The brother-in-law pled guilty to the theft of Government funds for taking money paid to his sister-in-law after her death. He was sentenced by the U.S. District Court for the Middle District of Florida to 48 months of supervised probation and ordered by the court to pay restitution of $90,187 to multiple Federal agencies. Of this restitution, OPM will receive $43,186.

Long-Term Motel Neighbors Steal Deceased OPM Annuitant's Identity

Our office learned that the November 2005 death of a retired Federal annuitant was never reported to OPM. OPM paid $308,391 in retirement annuity payments, and $76,883 in health insurance premium payments, after the annuitant's death.

We opened an investigation and identified two suspects, a married couple. After the annuitant's death, these individuals had stolen the annuitant's identity and changed the banking and address information on file with OPM. For 12 years, these two individuals used checks, wire transfers, and other methods to steal the annuity payments.

Unlike many cases involving the theft of OPM annuities, the subjects of our investigation were not related to and did not act as conservators or representative payees for the deceased annuitant whose identity was stolen. Our investigation found that the subjects knew the deceased annuitant because they were neighbors in a long-term motel.

The suspects in the case knew the deceased when they were neighbors in a long-term motel and perpetrated the fraud for 12 years after the annuitant's death.

Our attempts to interview the subjects were met with evasion and deception; however, we continued our investigation, and in August 2021, the subjects pled guilty to theft of Government funds in the U.S. District Court for the District of Nevada. On November 10, 2021, the two individuals were sentenced to 21 months of imprisonment and 36 months of supervised release. The court also ordered restitution of $308,391 due to OPM.

Daughter of Federal Annuitant Pleads No Contest to Elder Abuse

We received a request for information from a State law enforcement partner about a Federal annuitant who was hospitalized and then discharged to a rehabilitation facility in California. When payments to the rehabilitation facility stopped shortly after the annuitant arrived, it appeared the Federal annuitant had been abandoned by her daughter.

The investigation uncovered that the bank account where the Federal annuitant received the OPM annuity was active—and rent payments and purchases were being made in Las Vegas, Nevada. In all, the daughter of the Federal annuitant used $26,146 for her own purposes.

In September 2020, a felony complaint was filed in the State of California for elder abuse. On December 21, 2021, the daughter pled no contest to felony violation of California's elder abuse statute. She was sentenced to probation for 2 years, given credit for time served in jail, and ordered to pay restitution of $26,146.

Financial elder abuse is an allegation the Office of Investigations prioritizes for investigation because of its harm to the wellbeing and care of OPM annuitants.

Proactive Data Matching with FEHBP Data Warehouse Finds Multiple Deceased Annuitants

As part of our proactive investigations, we used a data matching project to compare FEHBP data warehouse records that identified individuals listed as deceased with retirement annuity information held by OPM about those same annuitants. We found several annuitants whose cases were not closed.

Ten individuals, so far, have been identified as deceased. The Retirement Services program office was generally not aware of these deaths. We gave the information from our project to the OPM Retirement Services program office to close the files, and it was able to use reclamation actions to recover $143,061 in overpayments made to the identified 10 individuals.

This proactive project is another tool for discovering improper payments and one that we can investigate expanding and making more periodic to better capture information about deceased annuitants. The success of this data matching project was based on a limited scope of data from the FEHBP data warehouse, and we look forward to exploring whether the project can be expanded in the future.

Agency Oversight and Integrity Investigations

One of the fundamental duties of the OIG is to investigate allegations of fraud, waste, abuse, or misconduct within OPM, its programs and its related contracts. This can involve investigations of administrative issues that affect OPM employees and contractors.

We take seriously our mission to investigate fraud, waste, and abuse in these programs so that OPM employees, Government employees, and the public can have faith in OPM operations.

As per the Inspector General Act of 1978, as amended, we must report to Congress in the Semiannual Report substantiated allegations in cases involving senior positions within OPM.

For this reporting period, we have no integrity-related investigations to report.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (Title 5 United States Code (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 a total of 37,609 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 362 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 1,468 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 (ASP).

Rhode Island Physician Debarred after Surrendering Medical License

In November 2021, we debarred a Rhode Island family medicine doctor who voluntarily surrendered his license in lieu of disciplinary actions. The doctor was being investigated for upcoding. Health care providers bill for services rendered using codes know as Current Procedural Codes (CPT). Health care insurers use the CPT codes to determine how much insurance pays for the services. Upcoding in billing involves using CPT codes to inflate the cost of actual services rendered, which includes: charging for complex medical procedures not performed; billing for more time during a doctor's visit than the actual time of the visit; and billing for more expensive equipment than

provided. The doctor's medical records reviewed during the investigation did not support the high-level billing of codes used. Also, his medical records were incomplete and did not include required patient assessments and treatment plans.

The State of Rhode Island Department of Health, Board of Medical Licensure & Discipline (Board) was notified by the Rhode Island Physician Health Program (PHP) that the physician who had a substance use disorder contract with the PHP was noncompliant with the terms of his contract.

In addition, the physician suffered from an unnamed medical condition. The PHP requested that he discontinue seeing patients until he could be reevaluated as to the level of care and oversight needed for his condition. The Board determined that allowing the physician to continue practicing medicine would constitute an immediate danger to the public in accordance with Rhode Island Rules and Regulations for the Discipline of Physicians (R5-37-MD/DO) section 11.4. The physician also surrendered his controlled substance registration and agreed to obtain appropriate treatment for his condition.

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

Our debarment of the physician will remain in effect for an indefinite period pending the resolution of his medical license. This case was referred to us by Blue Cross Blue Shield.

Ohio Physician and Medical Facility Debarred for Health Care Fraud

In October 2021, we debarred an Ohio physician based on his conviction in the U.S. District Court for the Northern District of Illinois, Eastern Division, after he was indicted for violating 18 U.S.C. § 1347, Health Care Fraud.

The charges stemmed from a scheme in which the physician submitted claims to Medicare and Blue Cross Blue Shield of Illinois (BCBS of Illinois) for procedures he did not perform. He created and caused the creation of false medical records, falsely identified medical procedures, and created fictitious patients. He submitted fraudulent claims for medical tests and examinations that were never performed and used some patient names without their knowledge to submit these claims. Between 2013 and 2017, the physician caused a loss of $950,000 in payments from Medicare and BCBS of Illinois, an FEHBP health carrier.

In December 2020, the physician pled guilty to the charges in the indictment. He admitted to participating in schemes that defrauded Medicare and BCBS of Illinois of nearly $1 million. He admitted that, as part of the scheme, he submitted over 10,000 fraudulent claims for diagnostic tests to BCBS of Illinois.

In May 2021, the physician was convicted and sentenced to 1 year and 1 day in prison for his role in a health care fraud scheme. The court also ordered him to pay restitution of $900,883 and a $100 fine.

Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. We debarred the provider for three years. In addition, the physician and his brother owned a medical facility that was used in committing the fraudulent activities. Based upon ownership and control, we also debarred the medical facility for three years. This case was referred to our office by Blue Cross Blue Shield.

Two Entities Debarred Based on Ownership by Debarred Physician

A debarred provider continued to submit reimbursement claims for supplies rendered during his debarment period. As a result, in January 2022, our office debarred two medical offices that were owned by the debarred provider.

In February 2021, our office debarred a provider, based on his exclusion by the Department of Health and Human Services (HHS). OPM's debarment and his HHS exclusion remain in effect.

In June 2021, the National Association of Letter Carriers Health Plan, an FEHBP health carrier, notified our office that they received notice that the provider wrote a prescription that was presented for fulfillment at a pharmacy. As a result, in September 2021, we issued a notice to the provider, reminding him of his OPM debarment which prohibits him from participating in the FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. We informed the provider that his action was a violation of his debarment terms. We also informed him that should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the Federal false claims statutes and potentially result in prosecution by a U.S. Attorney's Office. Additionally, the provider was informed that such claims may be a basis for the OIG to deny or delay future reinstatement into the FEHBP.

Statute 5 U.S.C. § 8902a(c)(2)(d) provides the authority to debar an entity that is owned or controlled by a sanctioned provider. The provider's violation prompted our ASP staff to investigate the entities with which the debarred provider was affiliated. The investigation identified two medical offices owned or controlled by the debarred providers which resulted in the January 2022 debarments of the entities. These debarments will coincide with the debarment terms of the provider who holds ownership or control.

These cases were identified by the Administrative Sanctions Program Group.

Pennsylvania Chiropractor and Practice Debarred for Five Years After Health Care Conviction

In October 2021, our office debarred a provider based on his July 15, 2020, conviction for one count of health care fraud. Our office also debarred the chiropractic practice owned and utilized by the debarred provider in the scheme.

On June 27, 2018, the OPM OIG Office of Investigations, coordinated with the U.S. Department of Labor (DOL) in reference to alleged fraudulent claims submitted by a Pennsylvania chiropractor. The Office of Investigations determined that the chiropractor engaged in a scheme using his practice to defraud health insurance carriers by billing for chiropractic services not rendered. On one occasion, the chiropractor billed for 2,000 hours of services in one day.

From approximately January 2017 through about August 2018, the chiropractor knowingly and willfully executed and attempted to execute a scheme and artifice to defraud health care benefit programs by submitting fraudulent claims for chiropractic services that he did not render. The chiropractor's fraudulent acts included:

- Routinely submitting claims for patients who failed to appear for scheduled appointments, falsely asserting that he saw the patients and provided chiropractic care; and
- Submitting fraudulent claims for days when he was not in the office and convalescing at home. Although he did not see any patients during this time, the chiropractor submitted fraudulent claims to give the appearance that he was keeping normal office hours and rendering chiropractic treatment.

The chiropractor submitted approximately $236,037 in fraudulent claims, of which the FEHBP paid approximately $74,110 to the chiropractor.

In January 2020, via a criminal information in the U.S. District Court for the Eastern District of Pennsylvania, the chiropractor was charged for violating 18 U.S.C. § 1347. In July 2020, the chiropractor pleaded guilty in the U.S. District Court for the Eastern District of Pennsylvania to one count of Health Care Fraud. In May 2021, he was sentenced to 5 years of probation, of which the first 6 months was to be served in home confinement.

Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. Mitigating factors and aggravation factors were considered; however, the aggravating factors led to the determination that a five-year debarment period was warranted. In addition, we debarred for a period of five years the chiropractic practice where the chiropractor held positions of control and financial responsibility and which was used as a tool to carry out his fraudulent activities.

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

Tennessee Doctor and Practice Debarred After Revocation of Medical Licensure

Our office debarred a Tennessee licensed medical doctor based on the Tennessee Board of Medical Examiners' (Board) revocation of her medical licenses. She had provided treatment including the prescribing of controlled substances to multiple patients from at least 2005. She was among the top 50 prescribers of controlled substances in the State of Tennessee for the 2012, 2013, 2014, and 2015 calendar years.

The Board found the doctor guilty of overprescribing controlled substances, namely: dispensing, prescribing, or otherwise distributing any controlled substance or any other drug not in the course of professional practice, or not in good faith to relieve pain and suffering, or not to cure an ailment, physical infirmity, or disease, or in amounts and/or for durations not medically necessary, advisable, or justified for a diagnosed condition. The doctor prescribed opioids in high doses in escalating levels, and at times prescribed patients greater than 300 morphine equivalent daily dose.

In addition, for several years the doctor prescribed opioids to her patients during the same period the patients were also taking other controlled substances (such as benzodiazepines) that can have a dangerous synergistic effect, and the documentation did not always reflect counseling on the risks associated with the drug combinations. Patients' medical files did not always show that the doctor counseled patients regarding anomalous urine drug screens, nor did they show that she always checked the Tennessee Controlled Substance Monitoring Database prior to prescribing controlled substances to the patients.

The Board issued a consent order permanently revoking the doctor's license, effective November 2020. In February 2022, our office debarred the doctor for an indefinite period, pending reinstatement of her medical license. Her license remains revoked. In addition, our office indefinitely debarred an entity owned by the doctor, effective February 15, 2022. The entity's debarment period will run concurrent with the terms of the doctor's debarment.

This case was identified by the Administrative Sanctions Program Group.

Evaluations 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 CIGIE. 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.

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

Legal and Legislative Activities

Under the IG Act, OIGs are required to obtain legal advice from a counsel reporting directly to an IG. This reporting relationship ensures that the OIG receives independent and objective legal advice. The Office of Legal and Legislative Affairs discharges this statutory responsibility in several ways, including by providing advice to the Immediate Office of the IG and the OIG office components on a variety of legal issues, tracking and commenting on legislative matters affecting the work of the OIG, and advancing legislative proposals which address waste, fraud, and abuse against and within OPM.

Over the course of the reporting period, the OIG's Office of Legal and Legislative Affairs advised the Inspector General and other OIG components on many legal and regulatory matters. The Office evaluated proposed legislation related to OPM and the OPM OIG's programs and operations. We also tracked and provided comments on proposed and draft legislation to both Congress and the CIGIE Legislative Committee.

Review of Postal Service Reform Act of 2022

On March 8, 2022, Congress cleared the landmark *Postal Service Reform Act of 2022* (H.R. 3076) (Act) for signature by the President. The Act establishes new enrollment procedures and benefit programs for U.S. Postal Service (USPS) employees and retirees. As part of those changes, the legislation establishes a new Postal Service Health Benefits Program (PSHBP) within the FEHBP. The Act ends USPS's statutory requirement to annually prepay future retirement health benefits for USPS employees and instead provides for coordinated enrollment of retirees under the PSHBP and Medicare.

After reviewing the statute and holding discussions with OPM, the OIG determined that the formation of the PSHBP within the FEHBP could substantially impact the OPM OIG's oversight activities. Accordingly, the OIG is developing a plan to successfully oversee the implementation of the Act. One item of particular concern relates to the Anti-Kickback Statute. As we have discussed in previous semiannual reports to Congress, the FEHBP is explicitly denied the protections of the Anti-Kickback Statute that are afforded to the other Federal health care benefit paying agencies, which prohibits medical providers from accepting a bribe or other remuneration in exchange for making a medical decision or referral. With the creation of the PSHBP within the FEHBP, we are very concerned that another OPM-administered health program is susceptible to fraud without an avenue for recourse when doctors take bribes to generate claims under the PSHBP. We look forward to engaging with Congress as we seek to find the most effective ways in which we can help ensure not only the successful implementation of the Act but also ways in which we can avoid potential risks to the program.

Technical Comments on the OPM Inspector General Modernization Act

In the fall of 2021, the OPM OIG was contacted by staff from the Senate Committee on Homeland Security and Governmental Affairs (HSGAC) to discuss legislation that would support our oversight activities. While OPM's annual appropriation for FY 2022 totaled $339,648,000, the agency annually disburses more than $140 billion in benefits through CSRS, FERS, FEHBP, and FEGLI, which are paid from OPM-administered trust funds amounting to over $1 trillion in assets. OPM also provides more than $40 billion in health care benefits annually to employees and retirees of the

Federal government. Meanwhile, for FY 2022, the OIG appropriations totaled $33,233,000, covering approximately 0.0033 percent of the total assets OPM's programs are responsible for managing.

HSGAC staff proposed a mechanism by which the OPM OIG could receive reimbursements for oversight activities by court order or otherwise agreed upon by the payor. This authority would allow the OPM OIG's skilled auditors and investigators to have supplementary resources to better leverage data analytics for the identification of fraud and control weaknesses in OPM's programs. As requested by the HSGAC staff, the OPM OIG provided technical comments on the proposed legislation. We also briefed the House Committee on Oversight and Reform staff on our analysis of the how the legislation would impact our office.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries:

Indictments and Criminal Informations	31
Arrests	25
Convictions	14
Criminal Complaints/Pre-Trial Diversion	0
Subjects Presented for Prosecution	38
Federal Venue	38
Criminal	20
Civil	18
State Venue	0
Local Venue	0
Expected Recovery Amount to OPM Programs	$4,779,493
Civil Judgments and Settlements	$2,025,936
Criminal Fines, Penalties, Assessments, and Forfeitures	$594,217
Administrative Recoveries	$2,159,339
Expected Recovery Amount for All Programs and Victims[14]	$90,336,533

Investigative Administrative Actions:

FY 2022 Investigative Reports Issued[15]	168
Issued between October 1, 2021 – March 31, 2022	168
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for 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	103

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued	362
FEHBP Provider Debarment and Suspension Inquiries	1,468
FEHBP Debarments and Suspensions in Effect at the End of Reporting Period	37,609

[14] 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.
[15] The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports.

Table of Enforcement Activities

Cases Opened	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations[16]	35	12	0	3	50
Preliminary Investigations[17]	43	10	0	3	56
FEHBP Carrier Notifications/ Program Office	836	10	0	1	847
Complaints – All Other Sources/ Proactive[18]	168	108	0	6	282

Cases Closed	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	31	12	1	2	46
Preliminary Investigations	56	13	0	6	75
FEHBP Carrier Notifications/ Program Office	916	8	0	1	925
Complaints – All Other Sources/ Proactive	152	107	0	3	262

Cases In-Progress[19]	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	129	37	0	5	171
Preliminary Investigations	33	18	0	0	51
FEHBP Carrier Notifications/ Program Office	40	8	0	0	48
Complaints – All Other Sources/ Proactive	30	9	0	0	39

OIG Hotline Case Activity

OIG Hotline Cases Received	1,029
Sources of OIG Hotline Cases Received	
Website	595
Telephone	238
Letter	69
Email	126
Facsimile	1
In-Person	0
OPM Program Office	
Healthcare and Insurance	**220**
Customer Service	61
Healthcare Fraud, Waste, and Abuse Complaint	148
Other Healthcare and Insurance Issue	11

[16] This includes preliminary investigations from this reporting period and previous reporting periods converted to investigations during this reporting period.
[17] This includes complaints or carrier notifications from this reporting period and previous reporting periods converted to preliminary investigations during this reporting period. Additionally, preliminary investigations include cases migrated from the previous case management system.
[18] Complaints excludes allegations received via the OPM OIG Hotline, which are reported separately in this report.
[19] "Cases In-Progress" may have been opened in a previous reporting period.

Retirement Services	**255**
Customer Service	87
Retirement Services Program Fraud, Waste, and Abuse	145
Other Retirement Services Issues	23
Other OPM Program Offices/Internal Matters	**24**
Customer Service	11
Other OPM Program/Internal Issues	10
Employee or Contractor Misconduct	3
External Agency Issue (unrelated to OPM)	**530**
OIG Hotline Cases Reviewed and Closed[20]	1,017
Outcome of OIG Hotline Cases Closed	
Referred to External Agency	**119**
Referred to OPM Program Office	**271**
Retirement Services	180
Healthcare and Insurance	80
Other OPM Programs/Internal Matters	11
Referred to FEHBP Carrier	**70**
No Further Action	**557**
Converted to a Case	**0**
OIG Hotline Cases Pending[21]	30
By OPM Program Office	
Healthcare and Insurance	5
Retirement Services	22
Other OPM Program Offices/Internal Matters	1
External Agency Issue (unrelated to OPM)	2

[20] Includes hotline cases that may have been received in a previous reporting period.
[21] 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

October 1, 2021, to March 31, 2022

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	3	$15,168,237
B.	Reports issued during the reporting period with findings	7	$8,188,953[1]
	Subtotals (A+B)	10	$23,388,029
C.	Reports for which a management decision was made during the reporting period:	4	$6,212,958
	1. Net disallowed costs	N/A	$6,404,514
	a. Disallowed costs during the reporting period	N/A	$6,422,054[2]
	b. Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$17,540[3]
	2. Net allowed costs	N/A	-$191,556
	a. Allowed costs during the reporting period	N/A	-$209,096[4]
	b. Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$17,540[3]
D.	Reports for which no management decision has been made by the end of the reporting period	6	$17,175,071
E.	Reports for which no management decision has been made within 6 months of issuance	3	$14,927,559

[1] This amount includes $119,796 for a previous semi-annual reporting period audit recommendation that was reclassified from a procedural recommendation to a monetary recommendation in this semi-annual reporting period.

[2] Represents the management decision to support questioned costs and establish a receivable during the reporting period. This amount includes $30,839 in additional costs disallowed after report issuance.

[3] 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.

[4] 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

October 1, 2021, to March 31, 2022

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 6 months of issuance	0	$

Appendix II

Resolution of Questioned Costs in Final Reports for Insurance Programs

October 1, 2021, to March 31, 2022

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$15,168,237
B.	Value of new audit recommendations issued during the reporting period	$8,219,792
	Subtotals (A+B)	$23,388,029
C.	Amounts recovered during the reporting period	$6,404,514[1]
D.	Amounts allowed during the reporting period	-$191,556
E.	Other adjustments	$0
	Subtotals (C+D+E)	$6,212,958
F.	Value of open recommendations at the end of the reporting period	$17,175,071

[1]This amount includes $30,839 in additional recovered costs after report issuance.

Appendix III

Final Reports Issued With Recommendations for Better Use of Funds

October 1, 2021, to March 31, 2022

Subject		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	2	$114,354,689
B.	Reports issued during the reporting period with findings	1	$421,040
	Subtotals (A+B)	3	$114,775,729
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	3	$114,775,729
E.	Reports for which no management decision has been made within 6 months of issuance	2	$114,354,689

Appendix IV

Insurance Audit Reports Issued

October 1, 2021, to March 31, 2022

Report Number	Subject	Date Issued	Questioned Costs
1A-10-13-21-006	Highmark Health in Pittsburgh, Pennsylvania	November 15, 2021	$820,767
1H-02-00-20-033	Hawaii Medical Service Association's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Caremark for Contract Years 2016 through 2019 in Honolulu, Hawaii	November 15, 2021	$4,843,222
1G-FP-00-21-004	BENEFEDS as Administered by Long Term Care Partners, LLC (dba FedPoint) for Contract Years 2017 through 2019 in Portsmouth, New Hampshire	December 6, 2021	$0
1A-10-44-21-001	Arkansas BlueCross BlueShield in Little Rock, Arkansas	December 6, 2021	$114,439
1A-99-00-21-019	Coordination of Benefits with Medicare at Select Blue Cross Blue Shield Plans for the Period 2019 through 2020 in Washington, D.C.	January 3, 2022	$107,108
1C-QA-00-21-003	Independent Health Association, Inc. in Buffalo, New York	January 7, 2022	$1,201,504
1C-WJ-00-19-004	Group Health Cooperative of South Central Wisconsin in Madison, Wisconsin	February 14, 2022	$0
1A-10-17-21-018	Health Care Service Corporation for Contract Years 2018 through 2020 in Chicago, Illinois	February 23, 2022 Reissued March 16, 2022	$982,117
TOTAL			$8,069,157

Appendix V

Internal Audit Reports Issued

October 1, 2021, to March 31, 2022

Report Number	Subject	Date Issued
4A-CF-00-20-044	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 8, 2021
4A-CF-00-21-027	The U.S. Office of Personnel Management's Fiscal Year 2021 Consolidated Financial Statements in Washington, D.C.	November 12, 2021
4A-CF-00-20-029	The U.S. Office of Personnel Management's Utilization of the Improper Payments Do Not Pay Initiative in Washington, D.C.	February 14, 2022

Appendix VI

Information Systems Audit Reports Issued

October 1, 2021, to March 31, 2022

Report Number	Subject	Date Issued
4A-CI-00-21-012	Federal Information Security Modernization Act Audit - Fiscal Year 2021 in Washington, D.C.	October 27, 2021
1A-10-42-21-011	Information Systems General and Application Controls at Blue Cross Blue Shield of Kansas City in Kansas City, Missouri	November 15, 2021
1A-10-44-21-017	Information Systems General and Application Controls at Arkansas Blue Cross Blue Shield in Little Rock, Arkansas	November 15, 2021
1H-01-00-21-022	Information Systems General and Application Controls at CVS Caremark in Scottsdale, Arizona	March 16, 2022
1D-80-00-21-025	Information Systems General and Application Controls at EmblemHealth in New York, New York	March 21, 2022
1C-NM-00-21-028	Information Systems General and Application Controls at Health Plan of Nevada in Las Vegas, Nevada	March 21, 2022

Appendix VII

Summary of Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2022

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[22]	Total
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, D.C.	September 23, 2008	1	0	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	0	6
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, D.C.	November 5, 2009	1	0	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	0	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	0	7
4A-CI-00-10-019	Federal Information Security Management Act for Fiscal Year 2010 in Washington, D.C.	November 10, 2010	1	0	41
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.	September 14, 2011	2	0	14
4A-CI-00-11-009	Federal Information Security Management Act for Fiscal Year 2011 in Washington, D.C.	November 9, 2011	1	0	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	0	7

[22] 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.

Report Number	Subject	Date Issued	Recommendations: Open Unresolved	Recommendations: Open Resolved[22]	Recommendations: Total
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, D.C.	November 5, 2012	1	0	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	0	3
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013	1	0	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	0	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	0	4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	3	0	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	0	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	0	7
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	3	0	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	0	5
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	0	6
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	4	0	4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	5	0	26

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[22]	Total
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	12	0	19
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	0	4
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York	June 30, 2017	0	1	15
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	0	8
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	14	0	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	14	0	18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	1	18	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	0	4
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5	0	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	0	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	0	4
4A-CI-00-18-044	Management Advisory Report - U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, D.C.	June 20, 2018	2	0	2

Report Number	Subject	Date Issued	Recommendations: Open Unresolved	Recommendations: Open Resolved[22]	Recommendations: Total
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	21	0	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	16	0	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	0	3
1C-8W-00-18-036	Information Systems General Controls at University of Pittsburgh Medical Center Health Plan in Pittsburgh, Pennsylvania	March 1, 2019	0	1	5
1C-LE-00-18-034	Information Systems General and Application Controls at Priority Health Plan in Grand Rapids, Michigan	March 5, 2019	0	1	10
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	0	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	1	0	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	2	0	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	0	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	0	2	2

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[22]	Total
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	0	7
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	0	23
1A-10-85-17-049	Claims Processing and Payment Operations at CareFirst Blue Cross Blue Shield in Owings Mills, Maryland	October 23, 2019 Reissued April 15, 2020	0	1	10
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	23	0	47
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	18	0	20
4K-ES-00-19-032	Evaluation of the Presidential Rank Awards Program in Washington, D.C.	January 17, 2020	4	0	4
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	February 27, 2020 Reissued March 31, 2020	2	0	2
4A-RS-00-18-035	The U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	4	8	12
4A-CF-00-20-014	The U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020	1	1	3
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	0	3

Report Number	Subject	Date Issued	Recommendations: Open Unresolved	Recommendations: Open Resolved[22]	Recommendations: Total
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	0	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	0	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	0	2	19
4A-CI-00-20-009	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020	11	0	11
4A-HI-00-19-007	The 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	The U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, D.C.	October 30, 2020	0	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	0	4
4A-CI-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020	24	0	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	19	0	21
1C-52-00-20-011	Information Systems General and Application Controls at Health Alliance Plan of Michigan in Troy, Michigan	November 30, 2020	0	2	14

Report Number	Subject	Date Issued	Recommendations: Open Unresolved	Recommendations: Open Resolved[22]	Recommendations: Total
1C-A8-00-20-019	Information Systems General Controls at Baylor Scott and White Health Plan in Dallas, Texas	December 14, 2020	0	7	12
1A-99-00-19-002	Duplicate Claim Payments at All Blue Cross Blue Shield Plans in Washington, D.C.	February 12, 2021	0	2	8
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021	0	1	2
4A-HI-00-18-026	Management Advisory Report - FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C.	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021	1	1	4
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	3	0	5
1C-8W-00-20-017	UPMC Health Plan, Inc. in Pittsburgh, Pennsylvania	June 28, 2021	12	0	17
1H-99-00-20-016	Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts in Washington, D.C.	July 29, 2021	3	0	3
4A-CI-00-20-034	The U.S. Office of Personnel Management's Office of the Chief Information Officer's Revolving Fund Programs in Washington, D.C.	September 9, 2021 Reissued November 22,2021	3	0	4
1C-SF-00-21-005	Information Systems General and Application Controls at SelectHealth in Murray, Utah	September 13, 2021	0	5	12
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	11	0	14
4A-CF-00-20-035	The U.S. Office of Personnel Management's Check Receipt Process in Trust Funds in Washington, D.C.	September 30, 2021	0	9	9

Appendix VIII

Most Recent Peer Review Results

As of March 31, 2022

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[1]
System Review Report on the National Railroad Passenger Corporation Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	December 16, 2021	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[3]	Compliant[2]
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[4]
External Peer Review Report on the Office of the Inspector General for the Library of Congress *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	July 22, 2021	Compliant

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

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

[3] Due to the COVID-19 pandemic, the latest Peer Review of the Office of Investigations was postponed and has been tentatively rescheduled for December 2022.

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

Appendix IX

Investigative Recoveries

October 1, 2021 – March 31, 2022

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			**$20,993,299**	**$2,159,340**
	Healthcare & Insurance		**$20,055,809**	**$1,221,850**
		Carrier Settlement Agreements	$19,765,849	$931,889
		Administrative Recoupment	$289,961	$289,961
	Retirement Services		**$937,490**	**$937,490**
		Administrative Debt Recoveries	$937,490	$937,490
Civil			$68,505,300	$2,025,937
	Healthcare & Insurance		$68,505,300	$2,025,937
		Civil Actions	$68,505,300	$2,025,937
Criminal			$837,935	$594,217
	Healthcare & Insurance		**$182,678**	**$35,847**
		Court Assessments/Fees	$225	$0
		Criminal Judgments/ Restitution	$182,678	$35,847
	Retirement Services		**$655,257**	**$558,370**
		Court Assessments/Fees	$100	$0
		Criminal Judgments/ Restitution	$655,257	$558,370
Grand Total			$90,336,533	$4,779,493

Index of Reporting Requirements

(*Inspector General Act of 1978, As Amended*)

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5(a)(2):	Recommendations regarding significant problems, abuses, and deficiencies	23–39
5(a)(3):	Recommendations described in previous semiannual reports for which corrective action has not been completed	OIG's Website
5(a)(4):	Matters referred to prosecutive authorities	40–52; 56–58
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5(a)(12):	Significant management decisions with which the OIG disagreed during this reporting period	No Activity
5(a)(13):	Reportable information under section 804(b) of the Federal Financial Management Improvement Act of 1996	No Activity
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5(a)(19):	Investigations substantiating misconduct by a senior Government employee	No Activity
5(a)(20):	Investigations involving whistleblower retaliation	No Activity
5(a)(21):	Agency attempts to interfere with OIG independence	No Activity
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