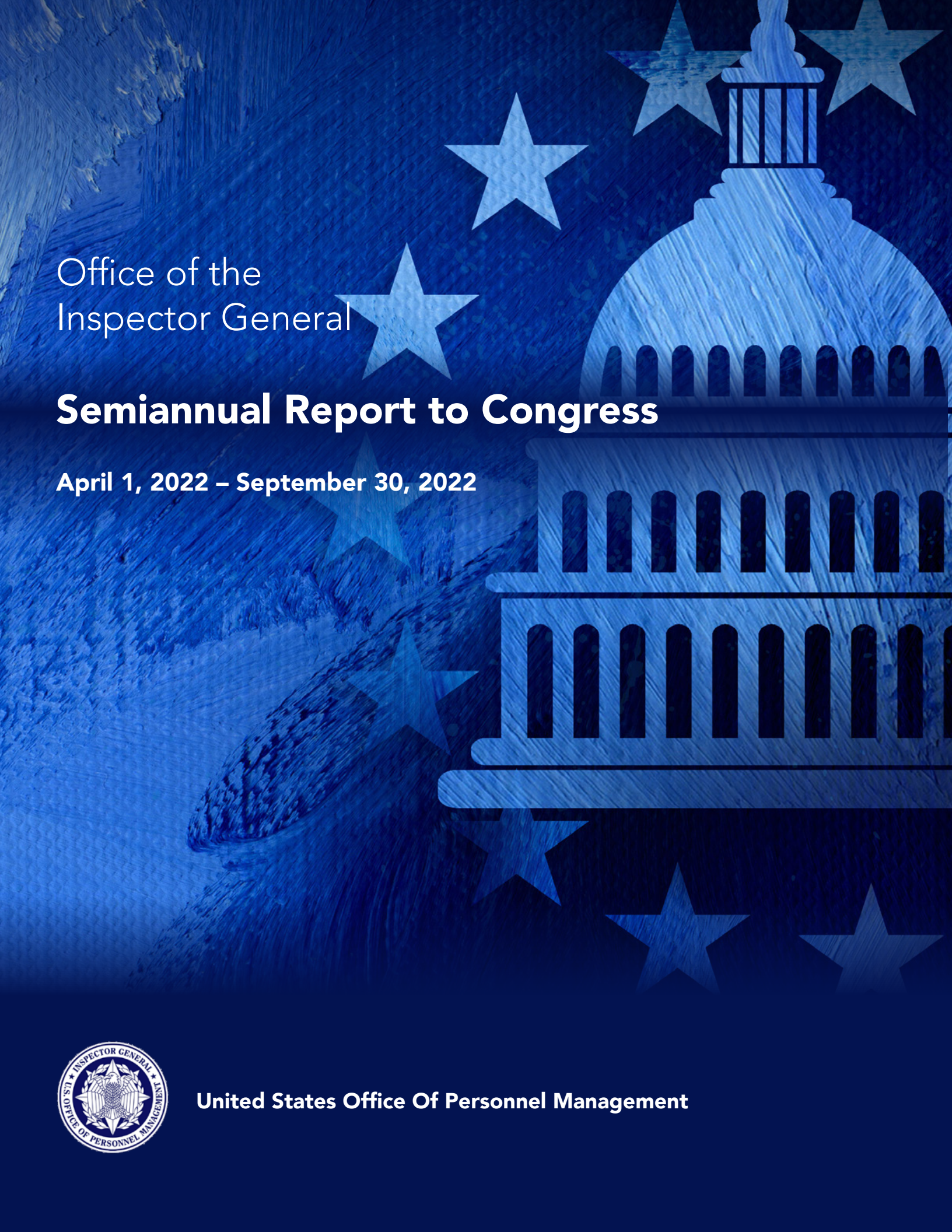


Office of the
Inspector General

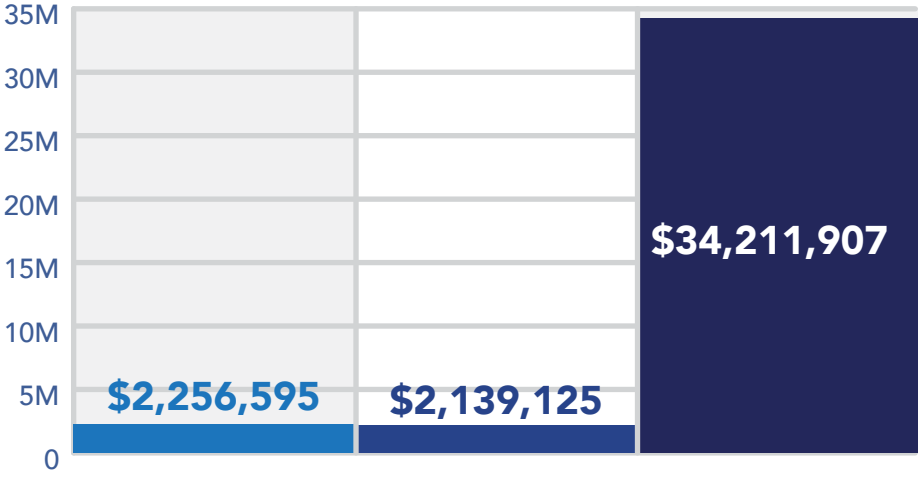
Semiannual Report to Congress

April 1, 2022 – September 30, 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

Audit Reports Issued	Evaluation Reports Issued	Data Briefs Issued	Management Advisories Issued	Investigations and Preliminary Investigations Closed	Indictments and Criminal Informations
20	0	0	0	101	5
2	11	1410	1292	488	1830
Arrests	Convictions	Hotline Contacts and Complaints Received	Hotline Contacts and Complaints Closed	Debarments and Suspen-sions of Federal Employees Health Benefits Program Providers	Debarment and Suspension Inquiries Regarding Federal Employees Health Benefits Program Providers

Message from the Inspector General

As the new Inspector General for the U.S. Office of Personnel Management (OPM), I am pleased to submit this semiannual report highlighting the work of the Office of the Inspector General (OIG) that was completed between April 1 and September 30, 2022. I want to express deep appreciation for Deputy Inspector General Norbert E. Vint who, prior to my confirmation by the U.S. Senate, honorably and effectively performed the duties of Inspector General for six years.

During my first months in the OIG, I have been impressed by the dedication and expertise of the OIG staff. The OIG has a talented team, including auditors, investigators, evaluators, attorneys, technology and support staff, that is forward thinking and committed to promoting accountability and oversight. I also appreciate the warm welcome I have received from OPM Director Kiran Ahuja as well as her open and cooperative engagement with the OIG.

I have several key goals. One goal is to ensure OPM addresses the hundreds of open recommendations from the OIG. These open recommendations cover a broad range of issues from weaknesses in information security to improper payments. OPM has begun to focus on addressing some of these open recommendations, including through a concentrated effort from Chief Information Officer Guy Cavallo. I am hopeful that the agency will continue to make progress on closing open recommendations. These recommendations provide a roadmap for the agency to become more effective and efficient in carrying out its mission.

I am committed to enhancing the data analytics capabilities of the OIG to strengthen our ability to conduct proactive oversight of OPM's programs and operations. I am also committed to providing additional transparency of the OIG's work to both promote the successes of the OIG and to improve accountability for OPM and the OIG. One example of the OIG's transparency-related initiatives includes a new OIG website (launched in May 2022) that makes it easier to search for reports and other OIG publications.

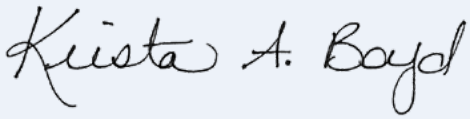
During this reporting period, the OIG had numerous accomplishments. The OIG issued 20 audit reports with 95 recommendations to improve the operations of OPM and its contractors. In just one example of the tenacious work of the OIG's Office of Audits, one contractor returned over $700,000 to the Federal Employees Health Benefits Program (FEHBP) Trust Fund as a result of the audit even before the OIG's final report was issued.

OIG investigations resulted in 11 convictions. The OIG investigative teams were chosen for several awards, including an award from the Council of the Inspectors General on Integrity and Efficiency (CIGIE) for work on a case involving Eargo, a direct-to-consumer hearing aid retailer that inappropriately sought reimbursement for its hearing aids. The OIG's efforts led to the recovery of $29.5 million for the FEHBP in a civil settlement.

During fiscal year (FY) 2022, the OIG's Administrative Sanctions Group issued 850 suspensions and debarments – surpassing the number of sanctions the OIG issued during the past two fiscal years. FEHBP health care providers may be debarred for a number of reasons, such as a criminal conviction based on delivery of, or payment for, health care services. At the end of the reporting period, there were a total of 38,006 active suspensions and debarments which prevented health care providers from participating in the FEHBP.

The Postal Service Reform Act of 2022, enacted in April, requires OPM to establish a new Postal Service Health Benefits Program (PSHBP) within the FEHBP. The OIG is committed to conducting strong, proactive oversight of OPM's implementation of this new program. Proactive oversight of OPM's development of the PSHBP is critical both to address challenges as they occur and to prevent fraud, waste, and abuse. It is essential that the OIG be adequately resourced in order to ensure robust oversight over the PSHBP while not jeopardizing other efforts to carry out the mission of the OIG.

The OIG is in the last stages of developing its strategic plan for fiscal years 2023-2028 utilizing strategic foresight to develop a bold plan of action to become a standard-bearer for the oversight community. With the leadership of the OIG's first Chief Diversity Officer, the OIG also continues to implement the OIG's Strategic Plan for Diversity, Equity, Inclusion, and Accessibility that was issued in April of this year. As we begin a new fiscal year, the OIG will continue to build on these accomplishments and continue to carry out our mission while delivering results for federal employees, annuitants, their families, and the public.



Krista A. Boyd
Inspector General

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.

Table of Contents

OIG Office Locations

Washington, District of Columbia
Cranberry Township, Pennsylvania
Jacksonville, Florida
Laguna Niguel, California

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 $59 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 BlueCross and BlueShield (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 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.

Health Insurance Plan of New York
New York, New York
Report Number 1C-51-00-21-024
June 23, 2022

The Health Insurance Plan of New York (Plan) has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in the greater New York City area. This audit covered contract years 2018 through 2020. During this period, the FEHBP paid the Plan approximately $234.3 million in premiums.

The Plan was unable to support remediation efforts to reimburse members impacted by incorrectly administered laboratory and diagnostic benefits.

We determined that the Plan did not comply with provisions of its contract and the laws and regulations governing the FEHBP for contract years 2018 through 2020.

Specifically, we found that the Plan:

- Did not maintain documentation to support aspects of its FEHBP premium rate development or the SSSG rate development;
- Did not have adequate internal controls over its process for calculating the Medicare loading;
- Incorrectly administered laboratory and diagnostic benefits for the standard option plan in 2019;
- Was unable to support reimbursements for members impacted by the laboratory and diagnostic benefit error;
- Did not report security data breaches affecting the FEHBP in a timely manner; and
- Did not properly configure its claims system to pay claims in accordance with its provider contracts.

Kaiser Foundation Health Plan, Inc.
Oakland, California
Report Number 1C-59-00-20-043
August 16, 2022

Kaiser Foundation Health Plan, Inc. (Plan) has participated in the FEHBP since 1960 and provides health benefits to FEHBP members in Northern and Southern California. This audit covered contract years 2016 through 2018. During this period, the FEHBP paid the Plan approximately $4.6 billion in premiums.

Due to limitations resulting from its use of an integrated health care system, the Plan is fundamentally unable to meet the reporting requirements required by the FEHBP MLR.

We were unable to determine if the Plan complied with the MLR requirements for years 2016 through 2018. The Plan utilizes an integrated health care system that was fundamentally unable to meet the FEHBP MLR reporting requirements.

Specifically, we found that the Plan:

- Had financial and pricing systems that tracked claims and membership data differently for its MLR reporting and premium rate calculations;
- Had system logic issues and claims payment errors that resulted in inaccurate data being used in the FEHBP MLR filings;
- Had insufficient internal controls and oversight over the Plan's systems used to report the data in the FEHBP MLR filings; and
- Was unable to accurately identify Medicare primary members under the age of 65.

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 $2.2 million to the OPM-administered trust fund.

BlueCross BlueShield 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 two recent BCBS audits that are representative of our work.

Cambia Health Solutions, Inc.
Portland, Oregon
Report Number 1A-10-69-21-021
May 20, 2022

Our multi-plan company audit of the FEHBP operations at Cambia Health Solutions, Inc. (Plan) covered miscellaneous health benefit payments and credits (such as refunds and medical drug rebates) and administrative expense charges pertaining to the Regence BlueCross and/or BlueShield plans of Idaho, Oregon, Utah, and Washington. We also reviewed the Plan's cash management activities and practices related to FEHBP funds and the Plan's fraud and abuse program activities.

We questioned $740,869 in medical drug rebates, net administrative expense overcharges, and lost investment income. We also identified a procedural finding for the Plan's cash receipt health benefit refunds. Our most significant administrative expense findings were that the Plan overcharged the FEHBP $475,037 for executive compensation costs and $78,726 for unallowable and/or unallocable cost center expenses. The BCBS Association and Plan agreed with all the questioned amounts as well as the procedural finding for the Plan's cash receipt refunds. As part of our review, we verified that the Plan returned these questioned amounts to the FEHBP.

The audit disclosed no findings pertaining to either (1) the Plan's cash management activities and practices related to FEHBP funds or (2) the Plan's fraud and abuse program activities. Overall, we determined that the Plan 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 submitting fraud and abuse cases to the OIG.

BlueCross BlueShield of Tennessee
Chattanooga, Tennessee
Report Number 1A-10-15-21-023
August 25, 2022

Our audit of the FEHBP operations at BCBS of Tennessee (BCBS of TN) covered the Plan's miscellaneous health benefit payments and credits, administrative expense charges, statutory reserve payments, cash management activities and practices, and fraud and abuse program activities. We questioned $916,907 in health benefit charges, administrative expense overcharges, cash management activities, and lost investment income. Because of the plan's lack of due diligence with recovery efforts, our most significant finding was that BCBS of TN had not recovered and/or returned $607,204 to the FEHBP for claim overpayments.

The BCBS Association and BCBS of TN agreed with $309,703 and disagreed with $607,204 of the questioned amounts. As part of our review, we verified that BCBS of TN returned the uncontested questioned amounts of $309,703 to the FEHBP because of the audit. As of the time of this semiannual report to Congress, one monetary recommendation remains open for the contested questioned charges of $607,204.

The audit disclosed no findings pertaining to BCBS of TN's statutory reserve payments or the plan's fraud and abuse program activities. Overall, we determined that BCBS of TN calculated and charged statutory reserve payments to the FEHBP in accordance with the contract and applicable laws and federal regulations. We also determined that BCBS of TN complied with the communication and reporting requirements for submitting fraud and abuse cases to the OIG.

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

Employee Organization Plans

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

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

We issued two audit reports of employee organization plans during this reporting period.

Audit of the Claims Processing and Payment Operations at the Mail Handlers Benefit Plan for Contract Years 2019 and 2020
Washington, D.C.
Report Number 1B-45-00-21-034
August 16, 2022

Our audit of the FEHBP claims processing and payment operations at Mail Handlers Benefit Plan (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 635 improperly paid claims resulting in FEHBP overpayments of $598,819. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Allowances applied for non-network drugs; and
- Claims paid after member terminations.

The audit also identified a procedural issue related to the Plan's debarment policies and procedures. Specifically, the Plan did not have procedures in place to notify the OIG when claims are submitted by providers debarred from the FEHBP after the effective date of their debarment, as required by the OIG's debarment guidelines.

The final report included two monetary and two procedural recommendations. The Plan agreed with all four recommendations and is in the process of implementing corrective actions to address them. All of the recommendations remain open.

Audit of the Claims Processing and Payment Operations at the Rural Carrier Benefit Plan for Contract Years 2019 and 2020
Washington, D.C.
Report Number 1B-38-00-21-033
August 19, 2022

Our audit of the FEHBP claims processing and payment operations at Rural Carrier Benefit Plan (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 one system error involving claims where an incorrect provider was identified and paid. The audit also identified a procedural issue related to the Plan's debarment policies and procedures. Specifically, the Plan did not have procedures in place to notify the OIG when claims are submitted by providers debarred from the FEHBP after the effective date of their debarment, as required by the OIG's debarment guidelines.

As corrective actions had been implemented by the Plan to address both audit issues prior to the issuance of the final report, this final report included no recommendations.

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 is responsible for 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 48 OPM-owned information systems as well as the 68 information systems used by private sector entities that contract with OPM to process federal data. We issued four IT system audit reports during the reporting period. Selected notable reports are summarized below.

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

Washington, D.C.
Report Number 2022-ISAG-0018
June 27, 2022

The Annuity Roll System (ARS) is one of the OPM's major IT systems. We completed a performance audit of ARS to ensure that the system's security controls meet the standards established by FISMA, the National Institute of Standards and Technology (NIST), the Federal Information System Controls Audit Manual, and OPM's Office of the Chief Information Officer (OCIO). Our audit of IT security controls of ARS determined that:

- A Security Assessment and Authorization was completed on February 17, 2021. The Authorization was granted for up to three years.
- The ARS security categorization is consistent with Federal Information Processing Standards 199, and we agree with the "moderate" categorization.
- OPM has completed a Privacy Impact Assessment and Privacy Threshold Analysis with an expiration date of January 2023.
- The ARS System Security Plan was complete and follows the OCIO's template.
- The OCIO performed a security assessment and has documented procedures and test cases.
- Continuous Monitoring for ARS was conducted in accordance with OPM's quarterly schedule for fiscal year 2021.

- The ARS contingency plan was completed in accordance with NIST Special Publication (SP) 800-34, Revision 1, and OCIO guidance.
- The ARS Plan of Action and Milestones documentation is up to date and contains all identified weaknesses.

We evaluated a subset of the system controls outlined in NIST SP 800-53, Revision 4. We determined that the security controls tested appear to be in compliance.

Audit of the Information Systems General and Application Controls at BlueCross BlueShield of Vermont
Montpelier, Vermont
Report Number 1A-10-28-21-030
June 27, 2022

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

- BCBSVT has developed an adequate risk management methodology and creates remediation plans to address weaknesses identified during risk assessments. BCBSVT also performs risk assessments of its third-party vendors.
- BCBSVT has adequate physical and logical access controls in place to grant, adjust, and remove access to facilities and information systems.
- BCBSVT has perimeter controls in place to protect against external threats. However, encryption at rest is not enabled on systems that store federal data.
- BCBSVT could improve internal segmentation between user and server networks. Additionally, there isn't a documented policy or procedure related to end-of-life software.
- BCBSVT could improve controls related to its vulnerability remediation process.
- BCBSVT has an established incident response program.
- BCBSVT has not updated its configuration change control policy and procedures to reflect current conditions. BCBSVT also does not document deviations from its security configuration settings.
- BCBSVT has contingency plans in place for claims-related operations.
- BCBSVT has documented and implemented an application change control process.

Audit of the Information Systems General and Application Controls at BlueCross BlueShield of Alabama
Birmingham, Alabama
Report Number 2022-ISAG-0006
August 22, 2022

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

- BCBSAL has adequate physical and logical access controls in place.
- BCBSAL has adequate network security controls in place.
- BCBSAL's enterprise security event monitoring and incident response programs are adequate.
- BCBSAL has adequate controls over its contingency planning program.
- BCBSAL has adequate application change control policies and procedures.

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. In addition, our auditors 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 Compliance with the Payment Integrity Information Act of 2019
Washington, D.C.
Report Number 2022-IAG-002
June 23, 2022

The Payment Integrity Information Act of 2019 (PIIA) (Public Law 116-117) aims to improve efforts to identify and reduce governmentwide improper payments. Agencies are required to identify and review all programs and activities they administer that may be susceptible to significant improper payments based on guidance provided by the Office of Management and Budget (OMB). Payment integrity requirements are published in the agency's annual financial statement in accordance with payment integrity guidance in OMB Circular A-136. The agency must also publish any applicable payment integrity information required in the accompanying materials to the annual financial statements in accordance with applicable guidance. The most common accompanying materials to the annual financial statement are the payment integrity information published on paymentaccuracy.gov. Agency Inspectors General review payment integrity reporting for compliance and issue an annual report.

The objective of our audit was to determine whether OPM met the requirements of the PIIA related to the formulation and inclusion of the payment integrity information in the annual financial statements and accompanying materials to the annual financial statements for fiscal year (FY) 2021. We determined that OPM is not in compliance with the PIIA for FY 2021. As shown below, OPM met 9 out of the 10 PIIA requirements:

Criteria for Compliance	Criteria Met?
1a.) Published payment integrity information with the annual financial statement and in the accompanying materials to the annual financial statement of the agency for most recent FY in accordance with OMB guidance.	Compliant
1b.) Posted the annual financial statement and accompanying materials required under OMB guidance on the agency website.	Compliant
2a.) Conducted Improper Payment risk assessments for each program with annual outlays greater than $10,000,000 at least once in the last three years.	Non-Compliant
2b.) Adequately concluded whether the program is likely to make Improper Payments and Unknown Payments above or below the statutory threshold.	Compliant
3) Published Improper Payment and Unknown Payment estimates for programs susceptible to significant Improper Payments and Unknown Payments in the accompanying materials to the annual financial statement.	Compliant
4) Published corrective action plans for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement.	Compliant
5a.) Published an Improper Payment and Unknown Payment reduction target for each program for which an estimate above the statutory threshold was published in the accompanying materials to the annual financial statement.	Compliant
5b.) Demonstrated improvements to payment integrity or reached a tolerable Improper Payment and Unknown Payment rate.	Compliant
5c.) Developed a plan to meet the Improper Payment and Unknown Payment reduction target.	Compliant
6) Reported an Improper Payment and Unknown Payment estimate of less than 10 percent for each program for which an estimate was published in the accompanying materials to the annual financial statement.	Compliant

In addition, we also found that:

- The Office of the Chief Financial Officer's Risk Management and Internal Control did not complete two risk assessments that should have been completed during FY 2021.
- Retirement Services did not meet its reduction target for FY 2021 and did not provide documentation supporting that OPM senior management determined the tolerable Improper Payment and Unknown Payment rate.
- There are two outstanding audit findings from prior years' audits.

OPM's Human Resources Solutions Controls over its Requisition, Examining Services, and Interagency Agreement Review Processes
Washington, D.C.
Report Number 4A-HR-00-21-031
September 14, 2022

Human Resources Solutions (HRS) operates under the provisions of 5 U.S.C. §1304(e), which authorizes OPM to establish a revolving fund and to perform personnel management services for other federal agencies on a cost reimbursable basis. HRS provides customized human capital and training products and services to federal agencies to maximize their organizational and individual performance and drive their mission results. This is done through four practice areas which offer a complete range of tailored and standardized human resources products and services: the Center for Leadership Development; the Federal Staffing Center's Staff Acquisition Group; Human Resources Strategy and Evaluation Solutions; and Human Capital Industry Solutions.

Our auditors completed a performance audit of HRS's requisition, examining services, and Interagency Agreement review processes. The objectives of our audit were to determine whether: HRS's Center for Leadership Development's internal controls over its requisition process are effective; the Federal Staffing Center's Staff Acquisition Group is following its Quality Assurance policies and procedures over its examining services; and Human Resources Strategy and Evaluation Solutions is following its policies and procedures for the Interagency Agreement Quality Control/ Quality Assurance review process.

We determined that HRS did not follow its policies and processes for preparing requisitions, completing examining services, and completing Interagency Agreement reviews. Specifically, the:

- Center for Leadership Development lacks controls over its requisition review and approval process. They did not provide 14 out of 30 purchase requisition approval forms that we requested, and we noted deficiencies in the remaining 16 samples that we tested.
- Staff Acquisition Group did not follow its Quality Assurance Plan for completing examining services. We noted that 83 out of 164 Case Review Checklists were not provided; 3 out of 81 Case Review Checklists we reviewed were incomplete; and there were deficiencies noted in their Project Vacancy Reviews.
- Human Resources Strategy and Evaluation Solutions did not follow its Quality Control/Quality Assurance policies and procedures for reviewing Interagency Agreements. In addition, their policies and procedures need to be updated.

HRS concurred with all eight of our recommendations.

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 Federal Long Term Care Insurance Program for Contract Years 2017 through 2019
Jacksonville, Florida and Cranberry Township, Pennsylvania
Report Number 1G-LT-00-21-013
September 12, 2022

We completed a performance audit of the FLTCIP with our primary focus being operations conducted by the John Hancock Life and Health Insurance Company (Contractor). Our audit consisted of a review of the program's administrative expenses, cash management, claims processing, and performance guarantees for contract years 2017 through 2019. Additionally, we reviewed the current FLTCIP Funded Status Report provided by the Contractor to determine whether premium rates were adequate to fund the program through future periods. Audit work was completed remotely at our offices in Jacksonville, Florida and Cranberry Township, Pennsylvania.

The FLTCIP is not currently funded to handle future anticipated claims at the current premium rates.

Our audit identified one program improvement area for the administration of the FLTCIP. Specifically, we determined that the Contractor and OPM need to strengthen their procedures and controls related to the FLTCIP funding status and the frequency of setting premium rates.

Based on the September 2020 FLTCIP Funded Status Report provided by the Contractor, the FLTCIP Experience Fund has an estimated deficit compared to what is needed to pay future claim obligations and expenses under moderately adverse assumptions. If the program continues without a premium increase or benefit decrease, it is projected that the Fund will be depleted by 2048,

at which point the Contractor would be obligated to pay future benefits under the fully insured arrangement. While benefits are contractually guaranteed to enrollees, OPM and John Hancock should work together to develop a strategy to manage any future premium increases.

No other audit issues were identified from our reviews of the administrative expenses, cash management, claims processing, and performance guarantees.

Audit of the 2018 and 2019 Combined Federal Campaigns
Jacksonville, Florida and Cranberry Township, Pennsylvania
Report Number 2022-SAG-007
September 7, 2022

We completed a performance audit of the 2018 and 2019 Combined Federal Campaigns (CFC). Our audit consisted of a review of the CFC's charity applications and fees, donation cycle, quality assurance surveillance plan, and campaign expenses. Audit work was completed remotely at our offices in Jacksonville, Florida and Cranberry Township, Pennsylvania.

Our audit found that the Central Campaign Administrator and its subcontractor, Total Administrative Services Corporation, properly administered CFC operations in accordance with the terms of the Contract and applicable federal regulations. However, our audit identified the following finding related to OPM's administration of the 2019 CFC that requires corrective action. OPM's Office of the Combined federal Campaign (OCFC) incorrectly approved payments of $164,212 more than the maximum allowable amount, as limited by OPM's task order contract for Penngood (one of the four outreach coordinators who provide CFC marketing, event and activity support, and training). OPM's OCFC agreed with our finding and recommendations and is undertaking corrective actions to resolve the issue.

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 $156 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 million current and retired federal civilian employees and eligible family members receive benefits through these programs. Our investigations safeguard OPM's financial and program integrity and protect those who rely on OPM programs. The Office of Investigations prioritizes investigations into allegations of harm against beneficiaries of OPM programs, the substantial loss of taxpayer dollars, and agency program vulnerabilities that allow fraud, waste, and abuse.

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

Some of the outstanding work that our investigators conducted culminated in national awards of excellence in addition to historic settlements. While we continuously acknowledge our Office of Investigations team for their ability to consistently collaborate with other agencies, conduct incredibly complex investigations, and constantly adapt to changing circumstances, it is especially meaningful to have those efforts recognized on a national stage.

One of the ongoing challenges for the Office of Investigations is the continued exclusion of the FEHBP from the Anti-Kickback Statute. The Anti-Kickback Statute makes it illegal for health care providers to knowingly and willfully accept bribes or other remuneration in exchange for business. Because of the FEHBP's exclusion, we are unable to protect the FEHBP and its members from improper conduct that, when committed against any other federally funded health care program, would otherwise constitute a federal crime. We continue to receive numerous case referrals with kickback allegations and have had to close these cases, leaving millions of FEHBP funds unrecovered because of the exclusion from the AKS. The Anti-Kickback Statute continues to not only preclude the FEHBP from recovering funds on common types of health care fraud criminal investigations and civil settlements, but also fails to provide an alternative path for recourse. This same exclusion applies to the new Postal Service Health Benefits Program (PSHBP), which is a new, separate program within the FEHBP carved out under the recent Postal Service Reform Act of 2022. The Office of Investigations has been working with our Office of Legal and Legislative Affairs and Congress to address this issue.

FEHBP Health Care Fraud Investigations

Our Office of Investigations pursues criminal, civil, and administrative investigations into fraud, waste, and abuse that affect the FEHBP. Our investigative workload is primarily made up of FEHBP investigations. These investigations protect FEHBP enrollees and their dependents from patient harm and safeguard the program's financial integrity. Patients are often the victims of financially motivated providers who prioritize material wealth over patient care and wellbeing. Improper payments due to fraud raise FEHBP costs, resulting in higher premium rates for federal employees and retirees.

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 most significant benefits provided to federal employees, retirees, and their families. However, the program is vulnerable to much of the same fraud, waste, and abuse as the general health care environment. Additionally, because the of the way the program delivers care (through a network of private health insurers contracting with OPM to provide health insurance services), the program experiences some unique vulnerabilities.

Below, we highlight some of the work we do to protect the FEHBP, its enrollees, and the financial integrity of the trust fund.

Hearing Aid Company Agrees to Pay $29.5 Million in the Largest FEHBP-Only Settlement with a Medical Equipment Company

In June 2019, the OIG received allegations from multiple FEHBP health insurance carriers that a direct-to-consumer hearing aid retailer was inappropriately seeking reimbursement for its hearing aids.

Customers, who were FEHBP members, believed they were eligible for the hearing aids based on website information or advertisements from the hearing aid retailer asserting that the devices were fully covered by insurance. These advertisements specifically targeted FEHBP members, referencing the program by name and claiming that the hearing aids would be covered at no cost under FEHBP benefits.

Coverage for hearing aids is a valuable benefit of some FEHBP health insurance plans, but it requires a medical diagnosis of hearing loss that is supported by diagnostic testing. The hearing aid retailer submitted claims stating that their FEHBP member customers had been tested for and diagnosed with hearing loss when, in fact, no such diagnoses were made. In most cases, customers never received the hearing tests required for the medical diagnosis. Even after an internal audit exposed the widespread use of these fraudulent claim codes, the company continued this behavior for several months afterward.

The case involved FEHBP members nationwide, and we determined that the hearing aid retailer was paid $45,678,569 from the FEHBP trust fund. On April 29, 2022, the hearing aid retailer entered into a civil settlement to resolve the allegations in the case, resulting in a net recovery to the FEHBP of $29,480,937.

This investigation received the Council of the Inspectors General on Integrity and Efficiency's (CIGIE) 2022 Award for Excellence in Investigations and the National Health Care Anti-Fraud Association's (NHCAA) 2022 Specialty Benefits Investigation of the Year Award. This case is particularly notable for its nationwide reach; the investigative team's ability to adapt to changing and challenging circumstances; and the culmination of these efforts resulted in the largest FEHBP-only settlement with a medical equipment company.

More information about this case is available from the Department of Justice (DOJ): https://www.justice.gov/opa/pr/hearing-aid-company-eargo-inc-agrees-pay-3437-million-settle-common-law-and-false-claims-act.

Defendants Sentenced in Tennessee for Multimillion Dollar Nationwide Telemedicine Pharmacy Fraud Scheme

On September 8, 2016, we received a request for investigative assistance from the U.S. Attorney's Office for the Eastern District of Tennessee regarding a provider who was prescribing expensive compounded medications to numerous patients without medical need or provider-patient interaction. The prescriptions were billed by pharmacies through schemes devised by a direct-to-consumer internet marketer that supports telehealth and was the source of patient referrals to the pharmacies.

The investigation (conducted by our office in conjunction with the HHS OIG, Food and Drug Administration's Office of Criminal Investigations, Homeland Security Investigations, U.S. Postal Service OIG, and the FBI) identified over 100 medical providers connected to the telemarketing firm. Pharmacies were brought into the scheme and split the insurance payments for the compounded prescriptions, which included lidocaine pain cream and various vitamins. The prescriptions were mailed to patients without any physician interaction, proper medical diagnosis, or follow-up. Patients were deceived into providing their insurance information to the telemarketing firm through false internet advertisements offering CBD (Cannabidiol) and stem cell research trials for pain, among other marketing methods. Patients were told that there would be no costs and the medicines were often portrayed as part of a free trial. Patients' insurance were often billed thousands of dollars each for the compounded medications. The investigation also identified a co-pay assistance program, which was a sham business agreement to make it appear to the pharmacy benefit managers that co-payments had been collected from patients.

In May 2022, seven individuals and seven related corporate entities were sentenced for their roles in the multimillion-dollar health care fraud scheme. The providers and pharmaceutical entities involved in this scheme received a combined sentence of 24.5 years in prison, 16 years of supervised release, fines ranging from $100 to $2,400. The providers and entities are also jointly and severally liable for restitution in amounts ranging from $76,000 to $5,000,000. Recovery to the FEHBP in the amount of $316,767.23 was made in a previous reporting period.

This investigation received the The National Health Care Anti-Fraud Association's (NHCAA) 2022 Investigation of the Year Award in recognition of the complexity of the scheme, the extraordinary financial impact of the fraud, and the impact on the patients involved.

More information about this case is available from the DOJ: https://www.justice.gov/usao-edtn/pr/defendants-sentenced-tennessee-multimillion-dollar-nationwide-telemedicine-pharmacy.

Washington State Health Care System Agrees to Pay Record-Breaking Health Care Fraud Settlement of $22.7 Million to Resolve Liability for Medically Unnecessary Neurosurgery Procedures

In April 2022, the United States Attorney for the Eastern District of Washington and the Washington State Attorney General held a joint press conference to announce the resolution of a major case involving health care fraud, elder abuse, and patient harm as well as the largest-ever health care fraud settlement in Eastern Washington.

Our involvement in the case began in February 2020, when we received a *qui tam* filed in the Eastern District of Washington alleging that two neurosurgeons employed by a large health care and hospital system knowingly made false claims to the federal government for reimbursement. The health care system included 51 hospitals in seven western U.S. states and paid the neurosurgeons based on a productivity metric that provided them a financial incentive to perform more surgical procedures of greater complexity. The allegations included that the defendants misrepresented imaging and operated without proper indications for surgery, including using non-existent symptoms to justify urgent surgeries, thus endangering patient safety.

Our investigation revealed that: medical documentation contained falsified, exaggerated, and/or inaccurate diagnoses that did not accurately reflect the patient's true medical condition; reimbursement was sought for certain surgical procedures not performed; and surgeries performed were of greater complexity and scope than was indicated and medically appropriate (thereby subjecting the patient to greater risk of harm and complications).

Although the recovery of $865,284 to the FEHBP was reported in the previous reporting period, this case was included because of the DOJ press release in April 2022 and to highlight our office's involvement in the record-breaking settlement for the Eastern District of Washington.

More information about this case is available from the DOJ: https://www.justice.gov/usao-edwa/pr/providence-health-services-agrees-pay-227-million-resolve-liability-medically.

Two Individuals Convicted in $1.4 Billion Health Care Fraud Scheme Involving Rural Hospitals in Florida, Georgia, and Missouri

After a 24-day trial, a federal jury in the Middle District of Florida convicted two individuals for their roles in a conspiracy that fraudulently billed approximately $1.4 billion for laboratory testing services in a sophisticated "pass-through" billing scheme involving rural hospitals.

The OIG began its investigation in 2016 after receiving multiple case notifications alleging that a number of critical access hospitals in rural Florida and Georgia were billing an abnormally high number of certain laboratory tests. To date, the impact to the FEHBP is determined to be an estimated $3.2 million loss.

The scheme made it appear that the rural hospitals themselves did the laboratory testing when, in most cases, it was performed by testing laboratories controlled by certain individuals. The evidence in the case showed that these individuals targeted and obtained control of financially distressed rural hospitals through management agreements and purchases. The individuals promised to save these rural hospitals from closure by turning them into laboratory testing sites, but instead billed for fraudulent laboratory testing that was often not medically necessary.

Much of the laboratory testing billed through these rural hospitals involved urine drug screening for vulnerable addiction treatment patients receiving care at sober homes or other substance abuse treatment facilities. After private insurance companies began to question the billings, they would move on to another rural hospital, leaving the rural hospitals they took over in the same or worse financial shape than before their acquisition.

The individuals were convicted of Conspiracy to Commit Heath Care Fraud, Wire Fraud, and Conspiracy to Commit Money Laundering, in addition to five counts of Health Care Fraud. As of the date of this reporting, sentencing has not been scheduled.

More information about this case is available from the DOJ: https://www.justice.gov/opa/pr/two-individuals-convicted-14-billion-health-care-fraud-scheme-involving-rural-hospitals.

Montgomery County "Goody Bag" Pill Mill Doctor Sentenced to 20 Years in Prison

In April 2016, we received an allegation from law enforcement partners alleging that a Philadelphia provider fraudulently billed insurers for medically unnecessary physical therapy, acupuncture, chiropractic adjustments, and prescription drugs.

Our investigation identified that patients received a "goody bag" filled with prescription drugs, that included topical analgesics, muscle relaxers, anti-inflammatories, and Schedule IV controlled substances for pain and anxiety. The provider directed the proceeds from the fraudulent billings to various personal bank accounts and real estate.

The provider pled guilty to nineteen counts of health care fraud and twenty-three counts of distribution of Schedule II and Schedule IV controlled substances. On May 9, 2022, the provider was sentenced to 20 years in prison and five years of supervised release; he was also ordered to pay $40,000 in fines and $3.9 million in restitution. As part of the settlement, the FEHBP Trust Fund received a net payment of $160,591.

More information about this case is available from the DOJ: https://www.justice.gov/usao-edpa/pr/montgomery-county-goody-bag-pill-mill-doctor-sentenced-20-years-prison.

Texas Diagnostics Company Agrees to Pay $16 Million to Resolve False Claims Act Allegations for Medically Unnecessary Tests

In April 2019, we received a *qui tam* complaint filed in the District of Massachusetts regarding a Texas-based clinical laboratory that allegedly ran additional tests without the treating physician's knowledge, consent, or order, and without a pathologist's review and individual determination of medical necessity.

The investigation determined that, from 2013 through 2018, the laboratory routinely and automatically conducted additional tests on biopsy specimens. Additional tests were conducted prior to a pathologist's review and without an individualized determination regarding whether additional tests were medically necessary.

On July 20, 2022, the laboratory agreed to pay $16 million to resolve allegations that it submitted false claims for payment to federal health care programs. As part of the settlement, OPM recovered $745,929 for the FEHBP.

More information about this case is available from the DOJ: https://www.justice.gov/usao-ma/pr/inform-diagnostics-agrees-pay-16-million-resolve-false-claims-act-allegations-medically.

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.

The majority of our investigations of OPM's Retirement Services programs involve improper payments made to deceased annuitants covered under the CSRS and FERS retirement programs. These cases may involve identity theft, including individuals forging documents used by OPM to verify the vital status of annuitants and their continued eligibility for benefits. In other instances, representative payees or conservators are subjects in our retirement fraud investigations. These cases are particularly egregious because they involve the most vulnerable members of society, the elderly and disabled, being victimized by those individuals entrusted to act in their best interests.

We open cases for investigation from mainly three sources: 1) cases we proactively identify; 2) cases referred by Retirement Services from their program integrity efforts (that include data matching activities and surveys); and 3) cases referred to us from law enforcement partners.

During this fiscal year, we proactively identified and opened 171 cases (68 of which were opened this reporting period) representing $2,203,548 in improper payments to deceased annuitants.[1] We identified the 171 cases for investigation via two sources of data: 1) reports extracted from OPM's Annuity Roll System of retirement claim numbers with suspended benefit payments and 2) health care claims data identifying enrollees as deceased.

During our investigations, we may learn that Retirement Services has already stopped making monthly annuity payments to an annuitant based on certain information (e.g., three consecutive annuity payments were cancelled); however, no effort was made to determine whether the annuitant is deceased, which would result in initiating the reclamation process and the identification of potential improper payments. In other cases, Retirement Services only stops issuing annuity payments when our proactive efforts reveal that an individual is deceased or no longer eligible for continued benefit payments.

During this fiscal year, Retirement Services referred 25 cases (17 of which were referred this reporting period) involving suspected fraudulent benefit payments that were identified via their data matching activities.

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—sometimes more than a decade—of improper payments.

We highlight below some examples of our investigative work of Retirement Services' programs this reporting period.

[1] The improper payments include annuity payments paid after death, health benefit premiums and occasionally life insurance payments.

Conservator Steals $142,000 in Disability Annuity Payments

In September 2018, we received a case referral from a law enforcement partner regarding the unreported death of a disabled daughter of a former federal employee. The disabled daughter died in March 1987 and because OPM was not timely informed of the death, continued to receive disability benefit payments totaling $142,000 until October 2018.

Our investigation identified that the disabled daughter's niece served as the conservator. During the investigation, the disabled daughter's niece confirmed to law enforcement agents that after her aunt's death, she transferred the benefit payments to her own personal checking account and used the funds for her own expenses.

On May 12, 2022, the conservator was sentenced to serve one day in jail and 24 months of supervised release. She was also ordered to provide restitution totaling $142,000 to OPM and to pay a $100 special assessment.

Son Steals Twelve Years of Deceased Father's Annuity Payments

In March 2020, we received a fraud referral from the Retirement Services program office regarding the unreported death of a federal annuitant. The annuitant died in January 2007, and because OPM was not timely informed of the death, annuity payments continued being paid through June 2019, resulting in an overpayment of $281,137.

OPM was made aware of the annuitant's death through the Department of Treasury's Do Not Pay (DNP) system. DNP operates a resource dedicated to preventing and detecting improper payments by providing a central platform with a variety of data matching and data analytics services to support agency programs in their efforts to prevent and detect improper payments.

Our investigation identified that the annuitant's son had stolen the benefit payments from a joint account he held with his father by making improper withdrawals following his father's death.

On September 2, 2022, the son agreed to pay OPM a negotiated settlement of $240,000, which was paid in full on September 13, 2022.

More information about this case is available from the DOJ: https://www.justice.gov/usao-sdtx/pr/houston-doctor-pays-240000-wrongful-receipt-retirement-benefit-payments.

OIG Identifies $164,594 in Improper Payments Made to Deceased Annuitant for 11 Years After Death

In December 2021, we located a death record for an annuitant showing a date of death in November 2007. Although Retirement Services suspended the annuity payments in October 2018, they did not initiate reclamation actions to recover the post-death annuity payments and health insurance premiums for the period of November 2007 through September 2018. Post-death annuity payments totaled $87,148 and post-death health benefit premiums totaled $77,447, for a total improper payment of $164,59.

Due to our proactive efforts, $116,582 was returned to the Civil Service Retirement and Disability Trust Fund via the Department of the Treasury's reclamation process. The recovery includes $39,135 in annuity payments and $77,447 in health benefit premium payments.

OIG Proactive Efforts Identify an Annuitant Who Was Paid a Total of $634,200 for 19 Years After Death

In April 2022 we located a grave record for an annuitant via an internet website identifying that the annuitant died in May 2000. When we referred the case to Retirement Services (RS), it was determined that although RS had suspended the annuity payments in 2019, they did not investigate whether the annuitant was deceased. Nor did they initiate the reclamation process. We determined that OPM made monthly annuity payments to the annuitant after his death totaling $634,200. Including the post-death health benefit premiums paid, the total improper payment in this case was $897,821. Based on our referral information, RS initiated reclamation actions with the Department of the Treasury. Recovery efforts netted $196,517 in post-death annuity payments from the financial institution and $263,620 in health benefit premiums, for a total recovery of $460,137. Due to the statute of limitations, we could not pursue this matter criminally.

OIG Identifies Annuitant Death from BCBS Claims Data Resulting in OPM Terminating Benefit Payments and the Recovery of Post-Death Benefit Payments Totaling $82,457

As part of an exploratory proactive project, we received a file of annuitants who, according to BlueCross BlueShield's records, were deceased. From this file, we identified an annuitant who was still receiving a monthly retirement annuity payment as of March 2022, almost two years after their death in April 2020. We determined that OPM made post-death annuity payments in the amount of $64,475. We referred this case to Retirement Services who initiated reclamation actions and recovered 100% of the improper payments in this case, which totaled $64,475 for the post-death annuity payments and $17,982 for the post-death health benefit premiums, resulting in a total recovery of $82,457.

Agency Oversight and Integrity Investigations

One of the fundamental duties of the OIG is to investigate allegations of fraud, waste, abuse, and 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, federal employees, and the public can have faith in OPM programs and operations.

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

In the span of 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 38,006 active suspensions and debarments which prevented health care providers from participating in the FEHBP.

> **Debarment** disqualifies a health care provider from receiving payment of FEHBP funds for a stated time period. The FEHBP has 18 bases for debarment. The most frequently cited provisions are for criminal convictions or professional licensure restrictions 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 488 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 1,830 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 group 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 eligible 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 Group (ASG).

Florida Physician Sanctioned for Kickback Scheme

In July 2022, our office suspended a Florida physician and his clinic after the physician was indicted in the United States District Court for the Middle District of Florida Tampa Division (Court) in violation of the following:

- Conspiracy, 42 U.S.C. § 1320a-7b(b)(1);
- Offering and Paying Remuneration Kickbacks and Bribes, 42 U.S.C. § 1320a-7b(b)(2) 18 U.S.C. § 2; and
- Soliciting and Receiving Remuneration Kickbacks and Bribes, 18 U.S.C. §§ 1028(a)(7) and 2.

According to the indictment from August 2012, through in or around July 2015, the physician was involved in a conspiracy to pay and receive kickbacks in connection with prescribing Subsys, an expensive form of liquid fentanyl designed to be applied under the tongue (sublingual spray), allowing it to rapidly enter the bloodstream. The physician was also charged with five counts of soliciting and receiving kickbacks in the form of speaker fees. The physician, a pain medicine specialist, owned and operated a pain management medical practice where he prescribed large volumes of Schedule II opioids.

The physician was recruited by the company that manufactured Subsys, as part of a sham speaker program to conceal and disguise kickbacks and bribes paid to high-prescribing doctors, as an inducement for them to prescribe the drug. Sales representatives from the corporation arranged speaker programs that were often only attended by family and friends, or repeat attendees, and included falsified or forged signatures of attendees. The company also bribed large Subsys-prescribers, like the physician, by hiring individuals close to him to work as company liaisons to facilitate the approval of insurance forms for Subsys, including those submitted for Medicare patients. He was paid more than $275,000 in illegal kickbacks and bribes from the company in connection with the sham speaker programs.

Our office suspended the physician and his clinic to protect the health and safety of the FEHBP enrollees. The physician and the clinic will remain suspended until his adjudication by the United States District Court for the Middle District of Florida Tampa Division. This case was referred to us by BlueCross BlueShield.

Ohio Physician Debarred for Distribution of Controlled Substances and Health Care Fraud

In June 2022, we debarred an Ohio physician based on his conviction in the United States District Court for the Northern District of Ohio Western Division for distribution of controlled substances and health care fraud.

Documents presented during the trial provided evidence that from 2007 through 2019, the physician repeatedly prescribed medically unnecessary controlled substances, including Oxycodone, Fentanyl, Morphine and Tramadol, outside the usual course of professional practice and not for a legitimate medical purpose.

He prescribed high doses of opioids and other controlled substances to patients without initiating a pain management improvement plan. He prescribed dangerous drug combinations, failed to consider a patient's state of addiction, and ignored warning signs of abuse. During the trial, prosecutors showed that patients suffered loss of employment, fractured families, and in 2015 one of his patients died from an accidental overdose.

In July 2021, a jury found him guilty of 101 charges stemming from overprescribing addictive medications, primarily opioids, to dozens of patients over a 10-year period. In addition, he was convicted on an additional 25 counts of health care fraud primarily stemming from his administration of methylprednisolone injections without medical necessity, which were charged to patients' Medicare or Medicaid insurance.

In March of 2022, after several delays, he was sentenced to 5 years in prison, 1 year of supervised release, and ordered to pay $460,000 in restitution. Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. We debarred the provider for five years. This case was referred to our office by BlueCross BlueShield.

Virginia Physician and Medical Facility Debarred for Health Care Fraud

In April 2022, we debarred a Virginia physician based on his conviction in the United States District Court for the Eastern District of Virginia, Norfolk Division on multiple counts of the following violations:

- Health Care Fraud, 18 U.S.C. § 1347;
- False Statement Related to Health Care Matters, 18 U.S.C. § 1035; and
- Aggravated Identity Theft, 18 U.S.C. § 1028A.

In June 2020, a federal grand jury returned a 62-count superseding indictment charging the physician with 26 counts of health care fraud, 33 counts of making false statements relating to health care matters, and 3 counts of aggravated identity theft. In November 2020, the physician was convicted on 52 of 62 counts charged in the indictments.

The conviction also required Criminal Forfeiture under 18 U.S.C. § 982(a)7. The court, in imposing sentence on a person convicted of a federal health care offense, ordered the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

The physician was arrested in 2019, after the FBI completed an investigation on him for performing unnecessary surgeries on patients. According to court documents, the physician filed fraudulent Medicaid claims after performing gynecological surgeries on women, sometimes without their consent. For the past 10 years he performed hysterectomies, removal of fallopian tubes and dilation without sound medical judgment or necessity. The FBI started investigating the physician after receiving a tip from a hospital employee who suspected he was performing unnecessary surgeries on unsuspecting patients.

Court documents reveal that the physician "aggressively encouraged" women to consent to procedures by telling them they had cancer or would develop cancer if they didn't have surgery. The physician justified the procedures and surgeries to insurance companies by falsifying patients' medical records to include statements patient did not make and symptoms they did not have. He also billed insurance companies for diagnostic procedures he didn't perform like hysteroscopies and colposcopies. He would then send false findings to justify other medical procedures. He submitted claims for $2.3 million in gynecological procedures and surgeries that were never done. The physician was sentenced to 59 years in prison and ordered to pay $18,563,323.18 in restitution.

Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. We debarred the provider for 59 years. In addition, the physician owned a medical facility that was used in committing the fraudulent activities. Based upon ownership and control, we also debarred the medical facility. This case was referred to our office by BlueCross BlueShield.

Psychiatric Clinic Debarred Based on Ownership by Debarred Provider

A debarred provider continued to submit claims for services rendered to FEHBP enrollees during his period of debarment. As a result, our office debarred a psychiatric clinic that was owned by the debarred provider. In August 2001, our office debarred a provider, based on his exclusion by the Department of Health and Human Services (HHS). Our debarment and his HHS exclusion remain in effect.

The Government Employees Health Association (GEHA) notified our office that they received claims for services rendered by the debarred provider during his debarment period. As a result, in February 2022, we issued a notice to the provider, reminding him of his OPM debarment which prohibits him from participating in FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. We informed the provider that his action was a violation of his debarment terms, and should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the federal false claims statutes and potentially result in prosecution by a United States Attorney. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Section 8902a(c)(2)(d), title 5 of the U.S. Code provides the authority to debar an entity that is owned or controlled by a sanctioned provider. The provider's violation prompted our ASG staff to investigate the entities with which the debarred provider was affiliated. The investigation identified a psychiatric clinic owned or controlled by the debarred provider, which resulted in the August 2022, debarment of the clinic. The debarment will coincide with the debarment terms of the provider who holds ownership or control.

This case was identified by the ASG.

Pennsylvania Osteopathic Clinic Debarred based on Ownership by Debarred Physician

In March 2022, our office debarred a physician/surgeon based on the suspension of his medical license by the Pennsylvania State Board of Osteopathic Medicine (Board). As a result, we also debarred the provider's osteopathic clinic in April 2022.

The Board's suspension was based on its findings that the physician failed to conform to the standards of acceptable and prevailing osteopathic medical practice by engaging in sexual misconduct with a then current patient; and made misleading, deceptive, untrue, or fraudulent representations by creating medical records which did not accurately reflect the condition of the patient. As a result of the physician's actions, the Board placed his license on a 36-month period of suspension, with the last 24 months stayed in favor of probation, effective December 2021. We debarred the physician in March 2022 based on the Board's disciplinary actions. In addition, we debarred the osteopathic clinic owned by the physician in April 2022.

OPM statute, 5 U.S.C. § 8902a(c)(1), provides the authority to debar a provider whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed, by a s State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity. In addition, debarment shall be for an indefinite period coinciding with the period in which the provider's license is revoked, suspended, restricted, or otherwise not in effect in the State whose action formed the basis for OPM's debarment. The provider's license remains suspended, and our debarment remains in effect.

Section 8902a(c)(2)(d), title 5 of the U.S. Code provides the authority to debar an entity that is owned or controlled by a sanctioned provider. The provider's actions and his licensure prompted our ASG staff to investigate the entities with which the debarred provider was affiliated. The investigation identified an osteopathic clinic owned or controlled by the debarred provider, which resulted in clinic's April 2022 debarment. The clinic's debarment will coincide with the debarment terms of the provider who holds ownership or control.

This case was identified by the ASG.

California Clinic Debarred Based on Ownership by Physician Debarred for Health Care Fraud

In March 2022, we debarred a physician based on his November 2020 conviction for 1 count of conspiracy to commit healthcare fraud. His debarment remains in effect and runs for a period of five years. As a result, in April 2022, we debarred a clinic controlled by the debarred provider.

The intent of the health care fraud conspiracy was for the individuals involved to unlawfully enrich themselves, by submitting and causing the submission of false and fraudulent claims for health care benefits. The conspiracy scheme involved inducing patients to visit clinics to receive free or discounted cosmetic procedures not covered by insurance. In exchange for the non-covered services, insurance information was obtained from the patients and used by the debarred provider and others to bill for unnecessary medical services and for services never provided.

Investigation by the ASG staff revealed that the debarred provider is the operator of the clinic which was used in the conspiracy scheme. Approximately $201,738 was paid to the clinic, as the result of claims the provider caused to be submitted to FEBHP insurance carriers during the scheme.

Section 8902a(c)(2)(d), title 5 of the U.S. Code provides the authority to debar an entity that is owned or controlled by a sanctioned provider. The provider's actions and affiliation with the clinic resulted in the April 2022 debarment of the clinic. The debarment will coincide with the debarment terms of the provider who holds ownership or control.

This case was identified by the ASG.

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 OIG's programs and operations. We also tracked and provided comments on proposed and draft legislation to both Congress and the CIGIE Legislative Committee.

Postal Service Reform Act of 2022 and the Exclusion of the FEHBP from the Federal Anti-kickback Statute

As addressed in the last Semiannual Report to Congress, we have closely reviewed the effect the newly enacted Postal Service Reform Act of 2022 has on the OIG's oversight activity. This reporting cycle, we met with the House and Senate authorization and appropriations committees to discuss the OIG's planned oversight and associated financial needs. With OPM receiving $70,500,000 (for fiscal year 2022 until expended) to establish the Postal Service Health Benefits Program (PSHBP) and implement the requirements of the law, it is essential that the OIG be resourced commensurate with OPM to ensure the PSHBP is implemented in an effective and efficient manner.

The OIG is committed to conducting strong, proactive oversight of the establishment and administration of the PSHBP within the OPM FEHBP. After conferring with the agency and reviewing the legislation, the OIG has determined that we cannot wait to begin oversight of implementation of the Act. Efforts are currently underway to establish the new PSHBP within the FEHBP and federal funds are being spent now.

The OIG will meet regularly with the Healthcare and Insurance PSHBP implementation team to provide oversight rather than waiting until OPM's implementation is completed. This proactive approach will strengthen OPM's controls and improve the chances of a successful implementation.

Early IG involvement and oversight of major program management activities are key to ensuring successful outcomes that deliver services to the public and safeguard taxpayer dollars. The OIG has first-hand experience with previous challenges OPM has encountered when the IG was not utilized for collaboration and proactive oversight. For example, OPM's ill-fated IT modernization project known as 'Shell' was initiated in 2016 without IG involvement. The project was ultimately a major failure for the agency and cost taxpayers tens of millions of dollars.

The OIG cannot delay until the PSHBP is established to begin oversight, and current investigative resources are already operating at maximum capacity investigating fraud, waste, and abuse in existing OPM programs. The OIG is particularly concerned about potential procurement fraud, hiring officials engaging in prohibited personnel practices, or other financial violations such as health care fraud that can occur once the PSHBP begins disbursing benefits. Enrollment eligibility

issues are also an area of concern for the OIG. The Office of Investigations has recently investigated these issues in OPM programs and is concerned the same issues could potentially affect the PSHBP.

We also raised with the authorizing committees the FEHBP's exclusion from the Anti-Kickback Statute. As we have identified in many Semiannual Reports to Congress and earlier in this report, the FEHBP is specifically excluded from the Anti-kickback Statute which results in an estimated loss of tens of millions of dollars to the Trust Fund. This exclusion impedes the OIG's ability to detect, investigate – and obtain restitution regarding – kickbacks that occur within the FEHBP. With the establishment of the PSHBP within the FEHBP, a new health benefits program is also vulnerable to fraud with no ability for the OIG to investigate or hold bad actors accountable. The OIG urges Congress to protect the FEHBP, the PSHBP, and the enrollees of both programs by amending the Anti-Kickback Statute to define the FEHBP as a federal health care program.

Impact of Section 5674, "Submission of Reports that Specifically Identify Non-Governmental Organizations or Business Entities," of House-passed FY 2023 National Defense Authorization Act on OIG Oversight

On July 14, 2022, the House passed the FY 2023 National Defense Authorization Act (NDAA), which included the Senate version of the IG Independence and Empowerment Act. The IG Independence and Empowerment Act includes many high priority matters for the Inspector General community. However, NDAA section 5674, "Submission of Reports that Specifically Identify Non-Governmental Organizations or Business Entities," raised several concerns for our office. This reporting cycle, we had bipartisan meetings with both our House and Senate oversight committees independently and as part of a group of OIGs with the Council of Inspectors General on Integrity and Efficiency (CIGIE) where we shared our concerns with NDAA section 5674.

NDAA section 5674 would require OIGs to give business entities and non-governmental organizations an opportunity to comment on final reports in which they are mentioned, regardless of whether the business entity was the subject of the audit. The OIGs would be required to post these comments on the OIG website. Further, the provision included a retroactive period, allowing for business entities and non-governmental organizations to comment on reports issued as far back as 2019.

We shared with the Senate Committee on Homeland Security and Governmental Affairs and the House Committee on Oversight and Reform our concern that NDAA section 5674 would result in unintended consequences and negatively impact the operations of OPM OIG's Office of Audits by increasing audit cycles while decreasing the number of audits OA can complete annually, creating a backlog of up to 200 final reports requiring comment, and potentially creating confusion for the agency with regards to audit resolutions of OIG findings.

The majority of the audits conducted by the Office of Audits are of business entities that contract with OPM to provide benefits to federal employees via the FEHBP and their agreements with Pharmacy Benefit Managers; Federal Employees Dental and Vision Insurance Program; FLTCIP; and the FSAFEDs program. During the audit process, these business entities have ample notification of the audit and many opportunities to provide information, clarify its position, and provide responses to the findings and wording included in our reports. Allowing an audited business entity an additional opportunity to respond after issuance of the final report would increase the time it takes to fully complete an audit since our auditors would need to review this additional response and potentially refute inaccurate or misleading statements. Additional time added to each audit would also decrease the number of audits that the Office of Audits can complete based on the availability of its limited resources.

Additionally, the retroactive requirement to allow non-governmental organizations or business entities the opportunity to respond to final reports from 2019 onward would be unduly onerous. These reports have been finalized for several years and corrective action addressing OIG recommendations is underway or already completed. The Agency could potentially be faced with unvetted, contradictory information regarding, at times, disputed report recommendations. This may hinder progress on closing open recommendations or even require reopening previously closed recommendations such as financial recommendations. The current audit process, including the audit resolution process, already provides ample opportunity for the audited business entity to provide documentation supporting its position. Allowing yet another opportunity to refute the findings and recommendations would potentially extend the audit resolution process, placing an additional burden on the Agency as well as our audit staff.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries:

Indictments and Criminal Informations	5
Arrests	2
Convictions	11
Criminal Complaints/Pre-Trial Diversion	0
Subjects Presented for Prosecution	55
Federal Venue	55
Criminal	22
Civil	33
State Venue	0
Local Venue	0
Expected Recovery Amount to OPM Programs	$34,211,907
Civil Judgments and Settlements	$30,839,833
Criminal Judgements and Restitution	$2,852,337
Administrative Recoveries	$519,737
Expected Recovery Amount for All Programs and Victims[2]	$406,984,122

Investigative Administrative Actions:

FY 2022 Investigative Reports Issued[3]	314
Issued between October 1, 2021 – March 31, 2022	168
Issued between April 1, 2022 – September 30, 2022	146
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	5
Personnel Suspensions, Terminations, or Resignations	0
Referral to the OIG's Office of Audits	0
Referral to an OPM Program Office	70

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued	488
FEHBP Provider Debarment and Suspension Inquiries	1,830
FEHBP Debarments and Suspensions in Effect at the End of Reporting Period	38,006

[2] This figure represents criminal fines/penalties and civil judgments/settlements, in addition to 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.
[3] 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[4]	49	13	0	1	63
Preliminary Investigations[5]	61	4	0	3	68
FEHBP Carrier Notifications/ Program Office	876	17	0	0	893
Complaints – All Other Sources/Proactive[6]	173	71	0	4	248

Cases Closed	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	59	16	0	2	77
Preliminary Investigations	17	5	0	2	24
FEHBP Carrier Notifications/ Program Office	792	8	0	0	800
Complaints – All Other Sources/Proactive	146	59	0	3	208

Cases In-Progress[7]	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	120	34	0	4	158
Preliminary Investigations	30	4	0	0	34
FEHBP Carrier Notifications/ Program Office	121	14	0	0	135
Complaints – All Other Sources/Proactive	19	21	0	0	40

[4] This includes preliminary investigations from this reporting period and previous reporting periods converted to investigations during this reporting period.
[5] 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.
[6] Complaints excludes allegations received via the OPM OIG Hotline, which are reported separately in this report.
[7] "Cases In-Progress" may have been opened in a previous reporting period.

OIG Hotline Case Activity

OIG Hotline Cases Received	1,410
Sources of OIG Hotline Cases Received	
Website	670
Telephone	574
Letter	82
Email	83
In-Person	1
OPM Program Office	
Healthcare and Insurance	**215**
Customer Service	97
Healthcare Fraud, Waste, and Abuse Complaint	114
Other Healthcare and Insurance Issue	4
Retirement Services	**521**
Customer Service	429
Retirement Services Program Fraud, Waste, and Abuse	90
Other Retirement Services Issues	2
Other OPM Program Offices/Internal Matters	**33**
Customer Service	22
Other OPM Program/Internal Issues	5
Employee or Contractor Misconduct	6
External Agency Issue (unrelated to OPM)	**641**
OIG Hotline Cases Reviewed and Closed[8]	1,292
Outcome of OIG Hotline Cases Closed	
Referred to External Agency	**92**
Referred to OPM Program Office	**456**
Retirement Services	365
Healthcare and Insurance	73
Other OPM Programs/Internal Matters	18
Referred to FEHBP Carrier	**72**
No Further Action	**668**
Converted to a Case	**4**
OIG Hotline Cases Pending[9]	139
By OPM Program Office	
Healthcare and Insurance	19
Retirement Services	76
Other OPM Program Offices/Internal Matters	4
External Agency Issue (unrelated to OPM)	40

[8] Includes hotline cases that may have been received in a previous reporting period.
[9] Includes hotline cases pending an OIG internal review or an agency response to a referral.

Appendices

Appendix I-A

Final Reports Issued With Questioned Costs for Insurance Programs

April 1, 2022, to September 30, 2022

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	6	$17,175,071
B.	Reports issued during the reporting period with questioned costs	3	$2,256,595
	Subtotals (A+B)	9	$19,431,666
C.	Reports for which a management decision was made during the reporting period:	3	$2,337,258
	1. Net disallowed costs	N/A	$2,139,125
	Disallowed costs during the reporting period	N/A	$2,487,737[1]
	Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$348,612[2]
	2. Net allowed costs	N/A	$198,133
	Allowed costs during the reporting period	N/A	-$150,479[3]
	Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$348,6122
D.	Reports for which no management decision has been made by the end of the reporting period	6	$17,094,408
E.	Reports for which no management decision has been made within 6 months of issuance	4	$15,888,385

[1] Represents the management decision to support questioned costs and establish a receivable during the reporting period.
[2] Represents questioned costs which were determined by management to be allowable charges per the contract, subsequent to an initial management decision to disallow and establish a receivable. The receivable may have been set up in this period or previous reporting periods.
[3] Represents questioned costs (overpayments) which management allowed and for which no receivable was established. It also includes the allowance of underpayments to be returned to the carrier.

Appendix I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

April 1, 2022, to September 30, 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 questioned costs	0	$164,212
	Subtotals (A+B)	0	$164,212
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	$164,212
E.	Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix II

Resolution of Questioned Costs in Final Reports for Insurance Programs

April 1, 2022, to September 30, 2022

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$17,175,071
B.	Value of new audit recommendations issued during the reporting period	$2,256,595
	Subtotals (A+B)	$19,431,666
C.	Amounts recovered during the reporting period	$2,139,125
D.	Amounts allowed during the reporting period	$198,133
E.	Other adjustments	$0
	Subtotals (C+D+E)	$2,337,258
F.	Value of open recommendations at the end of the reporting period	$17,094,408

Appendix III

Final Reports Issued With Recommendations for Better Use of Funds

April 1, 2022, to September 30, 2022

Subject		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	3	$114,775,729
B.	Reports issued during the reporting period with questioned better use of funds amounts	0	$0
	Subtotals (A+B)	3	$114,775,729
C.	Reports for which a management decision was made during the reporting period	1	$421,040
D.	Reports for which no management decision has been made by the end of the reporting period	2	$114,354,689
E.	Reports for which no management decision has been made within 6 months of issuance	2	$114,354,689

Appendix IV

Insurance Audit Reports Issued

April 1, 2022, to September 30, 2022

Report Number	Subject	Date Issued	Questioned Costs
1A-10-69-21-021	Cambia Health Solutions, Inc. in Portland, Oregon	May 20, 2022	$740,869
1C-51-00-21-024	Health Insurance Plan of New York in New York, New York	June 23, 2022	$0
2022-CRAG-031	Baylor Scott & White Health Plan's 2022 Proposed Rate Reconciliations in Temple, Texas	July 25, 2022	$0
2022-CRAG-034	AvMed Health Plan's 2022 Proposed Rate Reconciliations in Miami, Florida	August 1, 2022	$0
2022-CRAG-033	Priority Health's 2022 Proposed Rate Reconciliations in Grand Rapids, Michigan	August 5, 2022	$0
2022-SAG-0026	Delta Dental's 2023 Premium Rate Proposal for the Federal Employees Dental and Vision Insurance Program in San Francisco, California	August 5, 2022	$0
1C-99-00-21-029	Aetna HealthFund CDHP and Value Plan in Blue Bell, Pennsylvania	August 10, 2022	$0
1B-45-00-21-034	Claims Processing and Payment Operations at the Mail Handlers Benefit Plan for Contract Years 2019 and 2020 in El Paso, Texas	August 16, 2022	$598,819
1C-59-00-20-043	Kaiser Foundation Health Plan, Inc. in Oakland, California	August 16, 2022	$0
1B-38-00-21-033	Claims Processing and Payment Operations at the Rural Carrier Benefit Plan for Contract Years 2019 and 2020 in Alexandria, Virginia	August 19, 2022	$0
1A-10-15-21-023	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	August 25, 2022	$916,907
1G-LT-00-21-013	Federal Long Term Care Insurance Program for Contract Years 2017 through 2019 in Portsmouth, New Hampshire	September 12, 2022	$0
TOTAL			$2,256,595

Appendix V

Internal Audit Reports Issued

April 1, 2022, to September 30, 2022

Report Number	Subject	Date Issued
2022-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	June 23, 2022
4A-HR-00-21-031	The U.S. Office of Personnel Management's Human Resources Solutions Controls Over Its Requisition, Examining Services, and Interagency Agreement Review Processes in Washington, D.C.	September 14, 2022

Appendix VI

Information Systems Audit Reports Issued

April 1, 2022, to September 30, 2022

Report Number	Subject	Date Issued
1A-10-17-21-032	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois	June 23, 2022
2022-ISAG-0018	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuity Roll System in Washington, D.C.	June 27, 2022
1A-10-28-21-030	Information Systems General and Application Controls at BlueCross BlueShield of Vermont in Montpelier, Vermont	June 27, 2022
2022-ISAG-006	Information Systems General and Application Controls at BlueCross BlueShield in Birmingham, Alabama	August 22, 2022

Appendix VII

Combined Federal Campaign Audit Reports Issued

April 1, 2022, to September 30, 2022

Report Number	Subject	Date Issued
2022-SAG-007	2018 and 2019 Combined Federal Campaigns in Madison, Wisconsin	September 7, 2022

Appendix VIII

Other Reviews Issued

April 1, 2022, to September 30, 2022

Report Number	Subject	Date Issued
N/A	Review of the 2017 Presidential Management Fellows Program Application Process Redesign in Washington, D.C.	May 18, 2022

Appendix IX

Summary of Reports More Than Six Months Old Pending Corrective Action

As of September 30, 2022

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	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
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, D.C.	November 5, 2012	1	0	18

[10] As defined in OMB Circular Number 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 Number 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	Open Resolved[10]	Total
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
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

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	Total
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
L-2018-1	Management Advisory Report - Review of the U.S. Office of Personnel Management's Non-Public Decision to Prospectively and Retroactively Re-Apportion Annuity Supplements in Washington, D.C.	February 5, 2018	3	0	3
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	1	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-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	15	0	52

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	Total
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 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
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	1	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	11	0	23
1A-10-85-17-049	Claims Processing and Payment Operations at CareFirst BlueCross BlueShield in Owings Mills, Maryland	October 23, 2019 Reissued April 15, 2020	0	1	10

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	Total
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	17	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	1	0	3
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	3	0	8
4A-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
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	9	0	11

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	Total
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	7	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	6	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	3	0	4
4A-CI-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020	18	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
1C-A8-00-20-019	Information Systems General Controls at Scott and White Health Plan in Dallas, Texas	December 14, 2020	0	5	12
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
1C-8W-00-20-017	UPMC Health Plan, Inc. in Pittsburgh, Pennsylvania	June 28, 2021	6	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

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[10]	Total
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	2	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	1	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	6	9
4A-CI-00-21-012	Federal Information Security Modernization Act Audit Fiscal Year 2021 in Washington, D.C.	October 27, 2021	22	0	36
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	0	1	3
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	20	0	20
1C-QA-00-21-003	Independent Health Association, Inc. in Buffalo, New York	January 7, 2022	4	0	33
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	2	0	7
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	6	0	18
1H-01-00-21-022	Information Systems General and Application Controls at CVS Caremark in Scottsdale, Arizona	March 16, 2022	0	1	1
1D-80-00-21-025	Information Systems General and Application Controls at EmblemHealth in New York, New York	March 21, 2022	0	3	5
	TOTAL		347	60	1051

Appendix X

Most Recent Peer Review Results

As of September 30, 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[2]	Compliant[3]
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. General Services Administration Office of Inspector General)*	June 30, 2022	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] Due to the SARS-CoV-2 pandemic, the latest Peer Review of the Office of Investigations was delayed but is now underway and expected to be completed by January 2023.

[3] 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.

[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 XI

Investigative Recoveries

April 1, 2022, to September 30, 2022

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			**$914,502**	**$519,737**
	Healthcare & Insurance		**$40,870**	**$40,870**
		Carrier Settlement Agreements	$40,870	$40,870
	Retirement Services		**$873,632**	**$478,867**
		Administrative Debt Recoveries	$399,158	$399,158
		Bank Reclamation	$79,708	$79,708
		Referral to Program Office	$394,766	$0
Civil			**$53,894,808**	**$30,839,833**
	Healthcare & Insurance		**$53,654,808**	**$30,599,833**
		Civil Actions	$53,654,808	$30,599,833
	Retirement Services		**$240,000**	**$240,000**
		Civil Actions	$240,000	$240,000
Criminal			**$352,174,812**	**$2,852,337**
	Healthcare & Insurance		**$352,032,810**	**$2,710,335**
		Court Assessments/Fees	$10,600	$0
		Criminal Fines	$75,000	$0
		Criminal Judgments/ Restitution	$351,947,210	$2,710,335
	Retirement Services		**$142,002**	**$142,002**
		Criminal Judgments/ Restitution	$142,002	$142,002
Grand Total			**$406,984,122**	**$34,211,907**

Index of Reporting Requirements

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

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

Office of the Inspector General
U.S. Office Of Personnel Management

Theodore Roosevelt Building
1900 E Street, N.W., Room 6400
Washington, D.C. 20415 1100

Telephone: (202) 606 1200
Fax: (202) 606 2153

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