SEMIANNUAL REPORT TO CONGRESS

October 1, 2020–March 31, 2021

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

PRODUCTIVITY INDICATORS

FINANCIAL IMPACT

Audit Recommendations for Recovery of Funds
$7,695,289

Management Commitments to Recover Funds
$11,725,182

Recoveries Through Investigative Actions $21,272,280

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

ACCOMPLISHMENTS

23 Audit Reports Issued

Evaluation Reports Issued 0

Data Briefs Issued 1

Management Advisories Issued 0

311 Investigations and Complaints Closed

Indictments and Criminal Informations 25

230 Arrests

19 Convictions

1,132 Hotline Contacts and Complaints Received

Hotline Contacts and Complaints Closed 1,233

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

1,915 **Debarment and Suspension Inquiries Regarding Federal Employees Health Benefits Program's Providers**

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

As we have reported previously in our Semiannual Reports to Congress, Top Management Challenges Reports, and Audit Reports, the U.S. Office of Personnel Management (OPM) has struggled with adequately funding high priority, mission critical initiatives such as the modernization of retirement services and information technology (IT) systems. OPM's budget consists of discretionary appropriations, mandatory administrative authority, and the Revolving Fund. A portion of each of these accounts makes up the common services account OPM uses to fund the agency's administrative functions, including finance, IT, and human resources. Historically, the agency relied heavily on the former National Background Investigations Bureau (NBIB) to fund the common services account. With the transfer of NBIB to the Department of Defense (DoD) on October 1, 2019, the agency's funding challenges have been exacerbated.

When the background investigation function was transferred to DoD's newly created Defense Counterintelligence and Security Agency (DCSA), OPM faced a significant budget shortfall. The background investigation function was a large component of OPM, contributing over $2.24 billion in revenue to OPM's budget in fiscal year (FY) 2019. In FY 2020, OPM successfully mitigated the shortfall through DoD's buyback of certain IT and financial services from OPM, as well as by the inclusion of an additional $34.5 million approved by Congress and signed by the President in the FY 2020 appropriations bill. In FY 2021, the agency still anticipated a budgetary shortfall because of the NBIB transfer. While it is anticipated that DCSA will continue to buy back services through the end of FY 2022, this will not fully alleviate the funding gap. OPM requested an additional $25 million in support from Congress for FY 2021 to lessen the shortfall. Ultimately, OPM has been able to mitigate these shortfalls the past two fiscal years. However, the need to mitigate occurred because OPM did not properly plan for the loss of revenue. The planned transfer of NBIB to DoD was known several years before the background investigation function was actually moved, allowing OPM time to assess and adjust its budget requests.

Securing adequate funding has not been the agency's only priority the past two years. In September 2018, the former Administration announced its plan to merge OPM with the General Services Administration (GSA). Congress sought justifications for the initiative, but was not satisfied with the analysis and planning presented by the agency. Ultimately, Congress established limitations on the proposed merger, requiring the National Academy of Public Administration (NAPA) to complete an independent study in the FY 2020 National Defense Authorization Act by March 2021. By October 29, 2020, the former OPM Acting Director internally announced to OPM staff that the former Administration decided it was "no longer devoting time and energy to the merger and are focused on ensuring OPM can function as a standalone personnel agency for the Federal Government." Nevertheless, after devoting two years to the proposed merger activities, the negative impact on the agency was clear—OPM workforce morale was low and the agency suffered high staff and leadership turnover, with a number of positions left vacant. The proposed merger also created

confusion in the budget and appropriations process, with OPM and the OPM OIG submitting congressional budget justifications jointly with GSA and the GSA OIG for the past two fiscal years.

In March 2021, the findings of the Congressionally mandated NAPA independent study were published. The study did not find that any of the agency's identified challenges would be resolved by transferring OPM functions to GSA. The study also highlighted the negative effect of tenuous funding on OPM programs and operations. Unfortunately, two years of proposed merger activities prevented OPM from focusing fully on funding projects needed to improve and modernize OPM's IT platform, the processing of retirement claims, and the management and delivery of Federal employee benefits, such as the Federal Employees Health Benefits Program.

OPM will need to work with Congress and the new Administration to request additional funding to determine what, if any, internal reductions can be implemented. The challenge for OPM is to fund projects ensuring OPM's IT platform can meet OPM's basic technology needs, as well as formulate its budget to adequately address the modernization needs of its various program offices.

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

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

In our previous semiannual report, we discussed the impact of COVID-19 on the OPM-administered Federal Employees Health Benefits Program (FEHBP) population. Specifically, we discussed trends in COVID-19 testing and the use of preventive care services from February through August 2020. As the coronavirus pandemic continues to be a significant concern for the population served by the FEHBP, we expanded the scope of our analysis in this semiannual reporting period to cover trends in COVID-19 testing and the use of preventive care services through December 2020.

While the trends in preventive care appear to be improving, as shown in the following exhibits, the gains made in the last few months will not offset the significant decreases in care that were observed at the beginning of the pandemic. Consequently, we continue to have concerns about the delays in care and the potential impact to the health of FEHBP members. We issued a data brief outlining our concerns to OPM on January 6, 2021.[1] The data brief contained three recommendations aimed at mitigating the potential impact of the delays in preventive care to the FEHBP and its members. We will continue to work with OPM as they take action to address these concerns.

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

The data used for our analysis comes from our data warehouse, which includes health insurance claims submitted by participating FEHBP health insurance carriers. Because there are medical services provided that have not yet been reported to the carriers, there is a delay in obtaining a complete set of data. Based on our analysis, we believe we have received the vast majority of the claims data through December 2020, though a small number of claims will likely be submitted throughout 2021. For this reason, the figures represented in this semiannual report for February 2020 through August 2020 may vary slightly from those reported in the previous semiannual report.

Our analysis of COVID-19 test counts shows the number of tests administered was slightly lower in September than in August, and then rose each month through December 2020 (see Exhibit 1 on the next page).

1 Downward Trends in FEHBP Members' Use of Preventive Care Services Caused by the COVID-19 Pandemic, (available at https://www.opm.gov/our-inspector-general/publications/reports/2021/1k-99-00-20-046.pdf).

Exhibit 1: Total Test Counts per Month (2020)

Please note figures include only a subset of FEHBP Health Plans

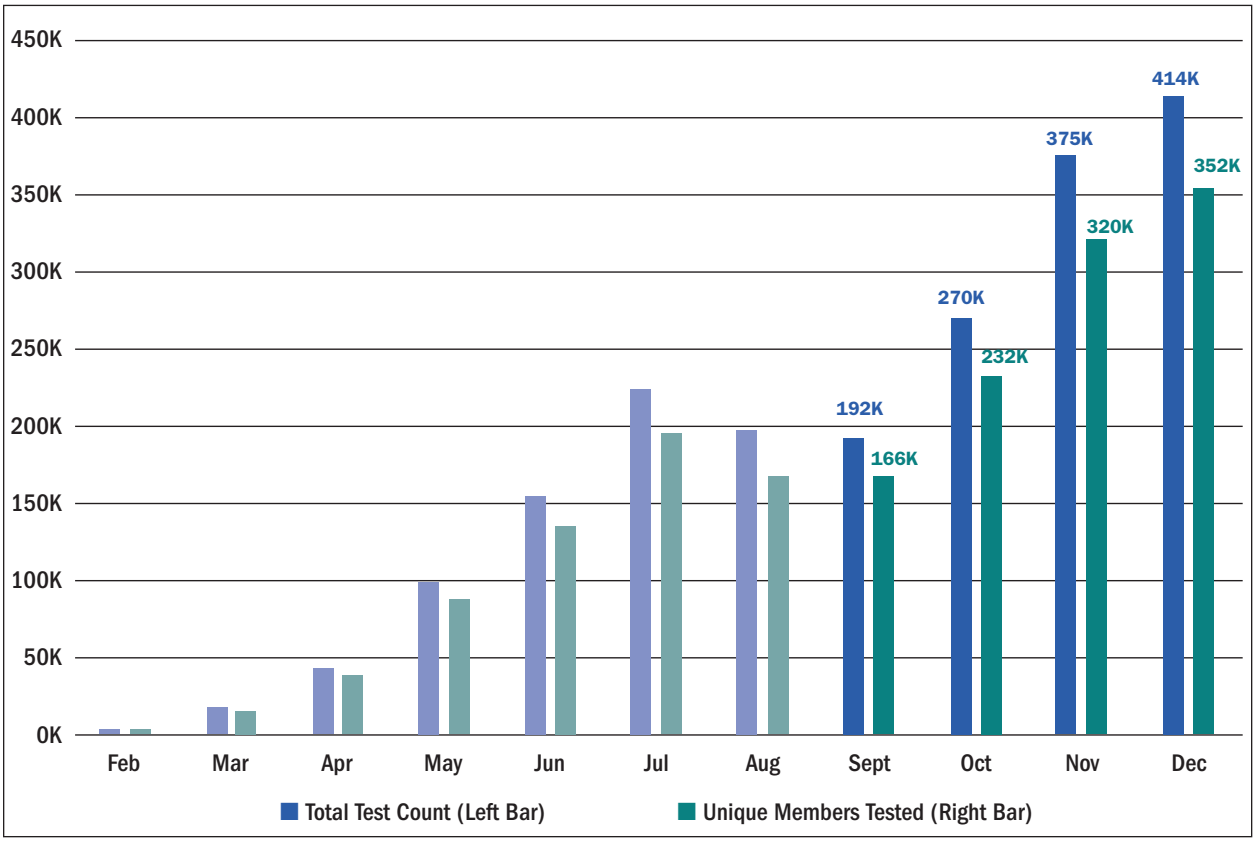


Exhibit 1: Total Test Counts per Month (2020). This bar graph shows the total test counts and unique members tested per month in 2020. Tests increased each month from February to July, then fell slightly in August and September, before increasing each month through December.

The average cost to the FEHBP of COVID-19 testing has remained consistent since the previous semiannual reporting period, with the average cost of a test between September and December 2020 totaling approximately $77. Given a total of 1,250,803 tests during this time period, this amounts to a total cost to the FEHBP of approximately $96 million.

In our last semiannual report, we also reported that a total of 55,353 FEHBP participants had been diagnosed with COVID-19 between February 1, 2020, and August 31, 2020. Our updated data now shows 58,324 diagnoses between February 1, 2020, and August 31, 2020. While we observed a slight dip in cases in September, cases began rising again in October and increased drastically between October and December, resulting in an additional 130,380 diagnoses from September to the end of the year (see Exhibit 2 on the next page).

Exhibit 2: Total Diagnoses per Month (2020)

Please note figures include only a subset of FEHBP Health Plans

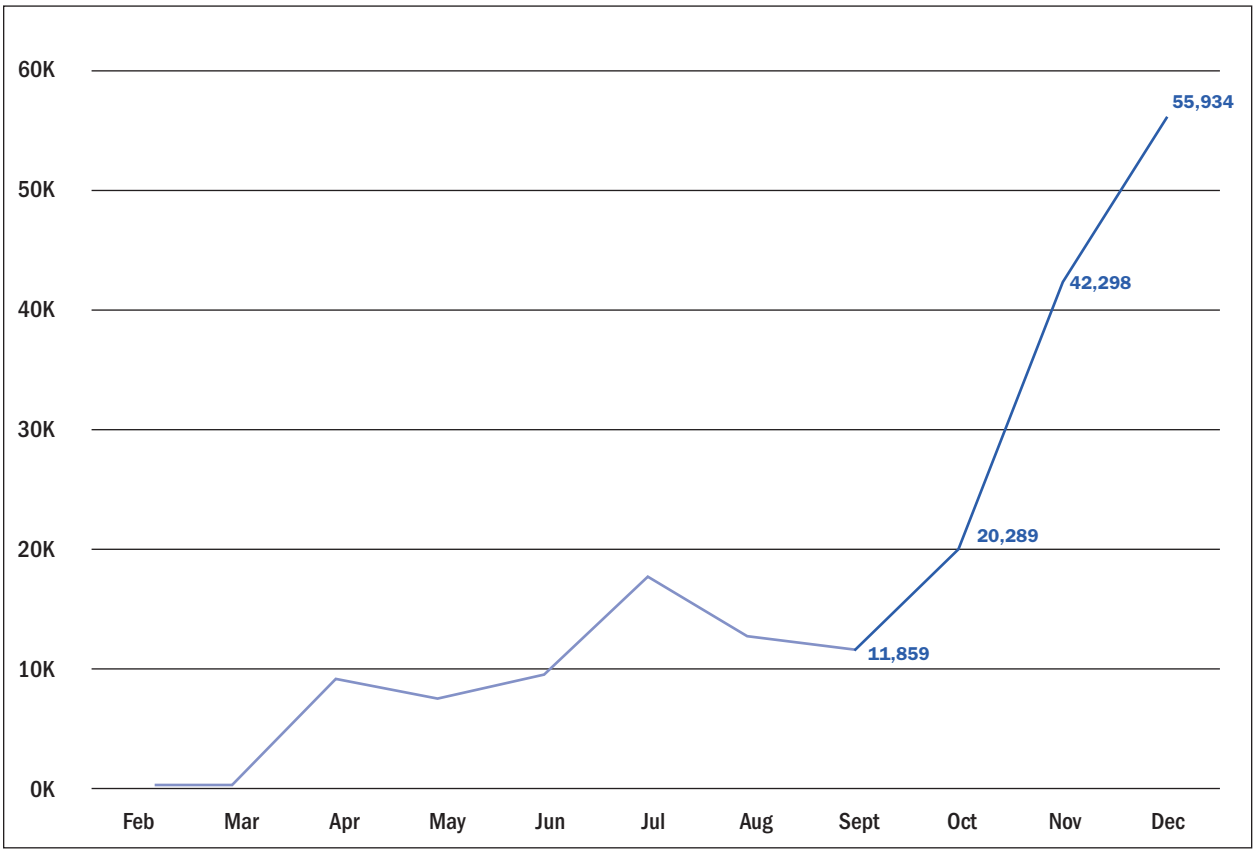


Exhibit 2: Total Diagnoses per Month (2020). This line graph shows the total COVID-19 diagnoses per month in 2020. Case numbers varied below 20,000 through September, then rose drastically each month from October to December, ending in roughly 56,000 diagnoses in the FEHBP in December alone.

While the number of diagnoses increased drastically from September to December 2020, the good news is that both the percentage of cases resulting in hospitalization and the cost of treatment reached much lower rates than those we were seeing when the pandemic first began. As we reported in our previous semiannual report, 94 percent of diagnoses in March of 2020 resulted in hospitalization, but this rate had decreased to 14 percent by August. Similarly, while the FEHBP paid about $31,000 per case for treatment in March, this dropped to only $2,000 per case for treatment by August. Thankfully, hospitalization rates and treatment costs seem to have evened out as the pandemic has continued.

A total of 130,380 FEHBP members were diagnosed with COVID-19 between September and December 2020

13% of cases resulted in hospitalization

Treatment cost an average of **$1,582 per case**

Unfortunately, cases have risen so dramatically since August that even though the percentage of in-patient hospital stays for COVID-19 has steadied around 13 percent, this still adds up to 16,809 total hospitalizations between September and December, versus 9,872 total COVID-19 hospital stays between January and August (see Exhibit 3 below).

Exhibit 3: Total Hospitalizations per Month (2020)

Please note figures include only a subset of FEHBP Health Plans

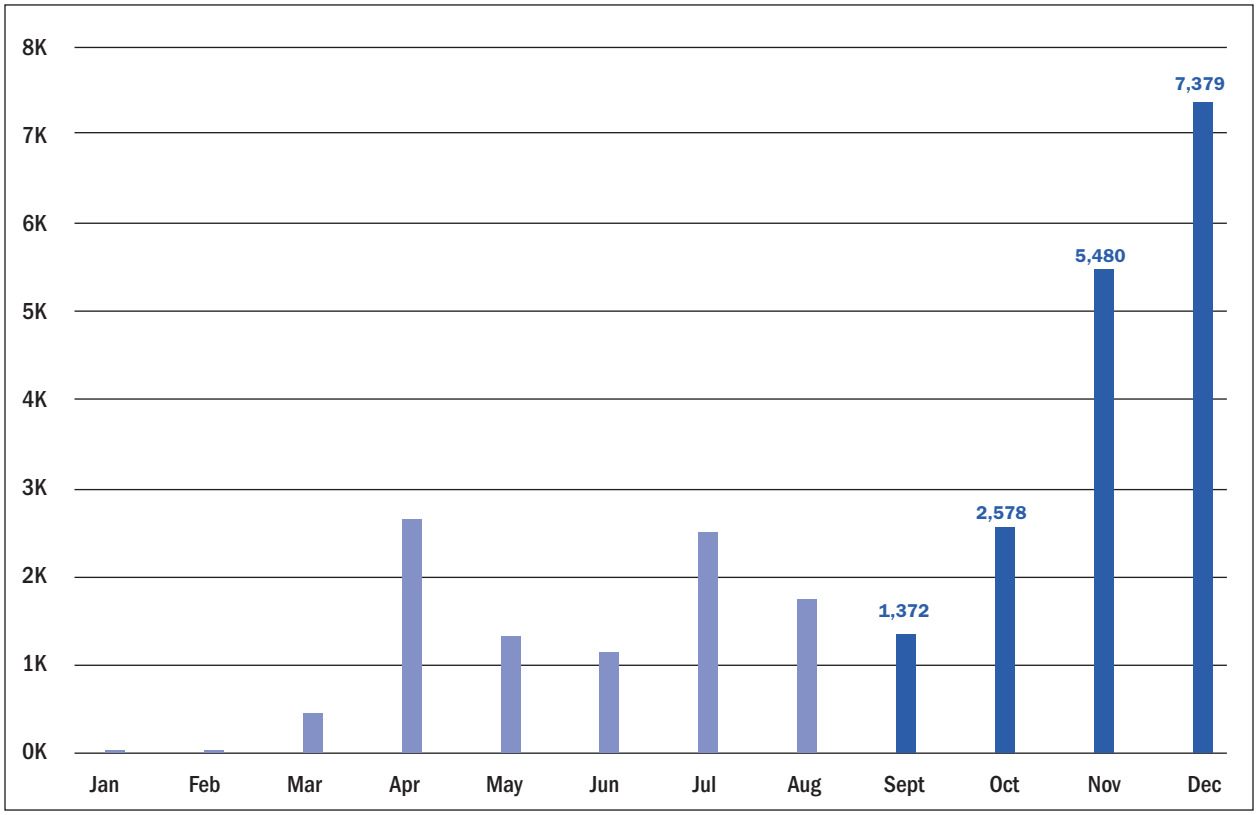
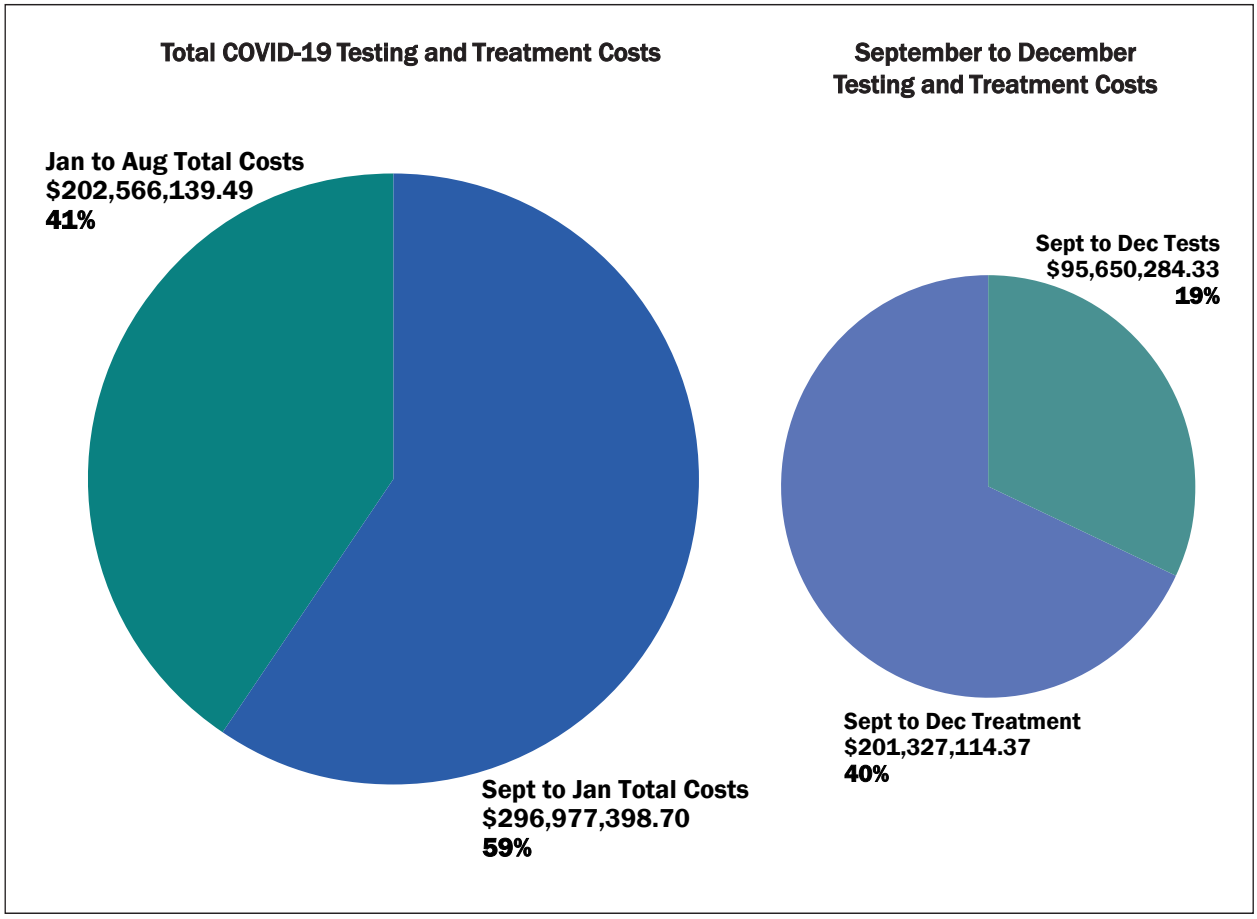


Exhibit 3: Total Hospitalizations per Month (2020). This bar graph depicts the number of hospitalizations per month in 2020. Hospitalizations were low in February and March, spiked in April, then fell again in May and June. Hospitalizations spiked again slightly in July, decreased in August and September, then rose drastically each month from October to December.

The total cost to the FEHBP of testing and treatment for COVID-19 between September and December 2020 was nearly $297 million. Added to the $56 million spent on testing from January to August and the $147 million spent on treatment during this time, the total cost to the FEHBP for diagnosing and treating COVID-19 from the beginning of the pandemic through December 2020 was about $500 million.

Exhibit 4: Breakdown of $500 Million Paid on COVID-19 Testing and Treatment

Please note figures include only a subset of FEHBP Health Plans



In our last semiannual report, we also expressed concern that preventive care claims from March to June 2020 had decreased about 35 percent overall from the previous year. There was an uptick in claims from May to July, but we began seeing a decrease again in August. However, our more updated data demonstrates that preventive care utilization remained steady from July to October (see Exhibit 5 on the next page).

We are seeing a slight dip in preventive care claims again from October to December. We believe this can be explained by the normal slowdown in pediatric immunizations after the beginning of the school year. When compared to rates from 2019, the total number of preventive care claims between October and December of 2020 were less than half a percentage point lower.

It is important to note that the number of individuals covered by the FEHBP health care carriers included in our analysis increased by 1.54 percent from 2019 to 2020. As such, preventive care utilization is about two percent lower than we would expect. While this may seem insignificant, it is a reminder that the gains made in the last few months have not been enough to offset the significant decreases in care that were observed at the beginning of the pandemic.

Exhibit 5: Total Preventive Care Claims per Month (2020)

Please note figures include only a subset of FEHBP Health Plans

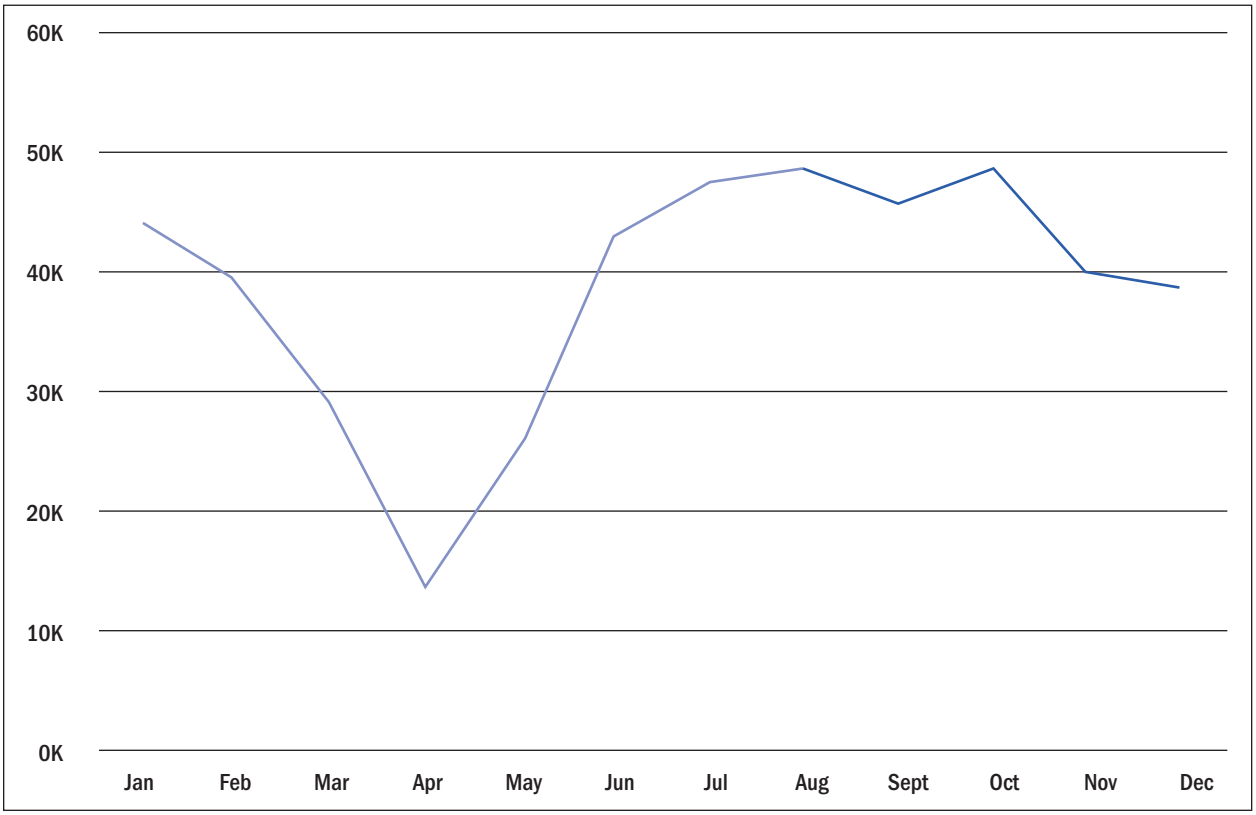


Exhibit 5: Total Preventive Care Claims per Month (2020): In this line graph, the line depicts the overall preventive care trend for FEHBP participants from January to December 2020. The line drops drastically from February to April, then picks up again through August. There is a slight dip in September, a raise in October, then a decrease again in November and December.

Exhibit 6: Percent Change in Preventive Care Claims Each Month of 2020 as Compared to 2019

Please note figures include only a subset of FEHBP Health Plans

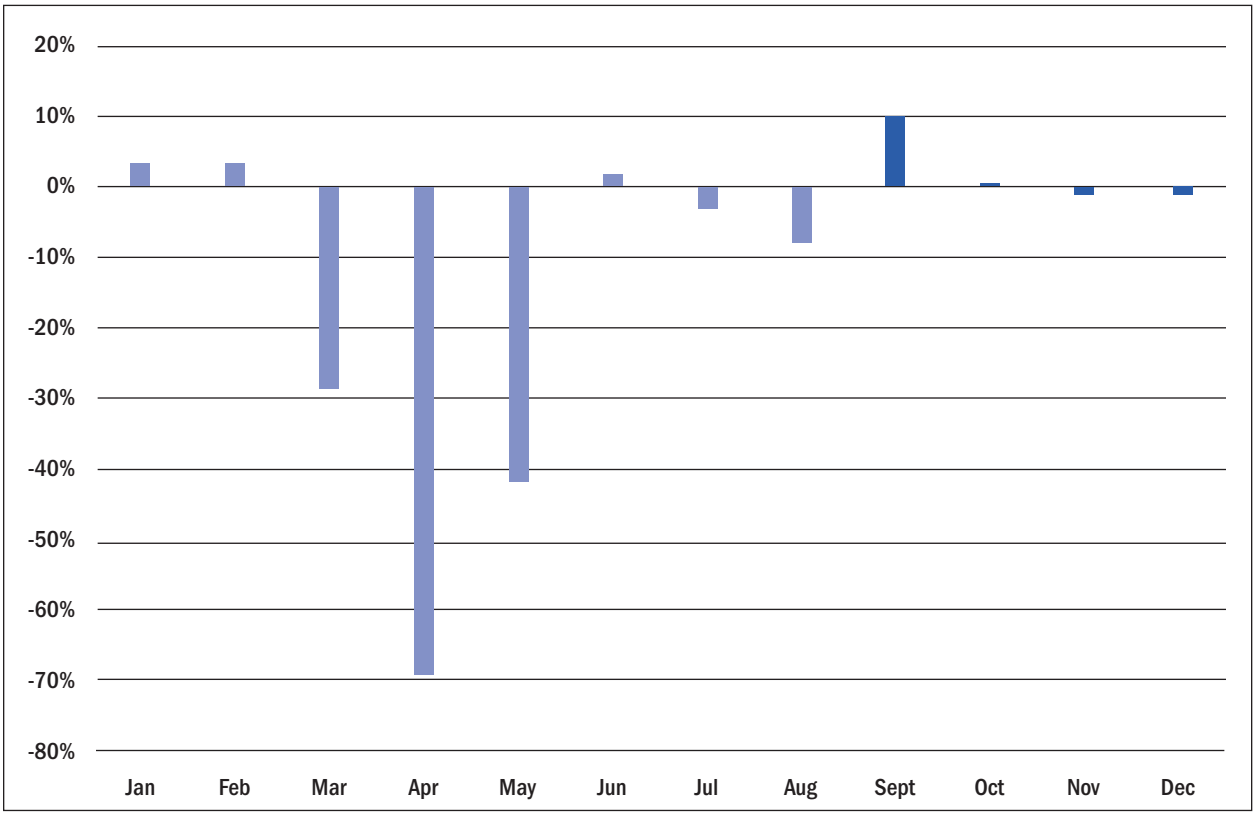


Exhibit 6: Percent Changes in Preventive Care Claims Each Month of 2020 as Compared to 2019. This bar graph compares preventive care claims per month in 2020 versus 2019. The percent change in January and February is slightly above zero, then falls dramatically below zero in March through May. Claims rose slightly above zero in June, then fell below zero again in July and August. The change in preventive care claims rose to about 10 percent in September, fell close to zero in October, then fell slightly below zero again in November and December. Overall, the percent change was negative in seven out of twelve months.

In our last semiannual report, we reported that telehealth utilization had dramatically increased in March and April of 2020, before beginning to dip slightly in May. While telehealth claim utilization continued to decrease through August, it has been relatively stable since, but at a rate much higher than before the pandemic began. With a total of 8,045,990 telehealth claims recorded in 2020 as compared to just 135,625 in 2019, this amounts to a huge 5,833 percent increase in telehealth claims over the past year. As we stated in our last semiannual report, while the use of telehealth services may be beneficial in some situations, it cannot replace routine diagnostic testing. Furthermore, with the significant uptick in use of telehealth services by FEHBP members, this is definitely an area that will warrant further review and oversight.

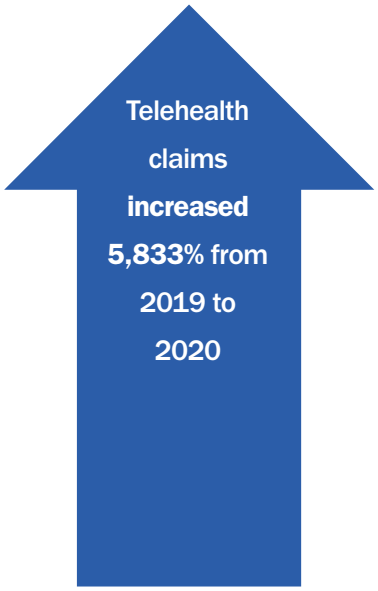


Exhibit 7: Trend in Telehealth Claims from January to December 2020

Please note figures include only a subset of FEHBP Health Plans

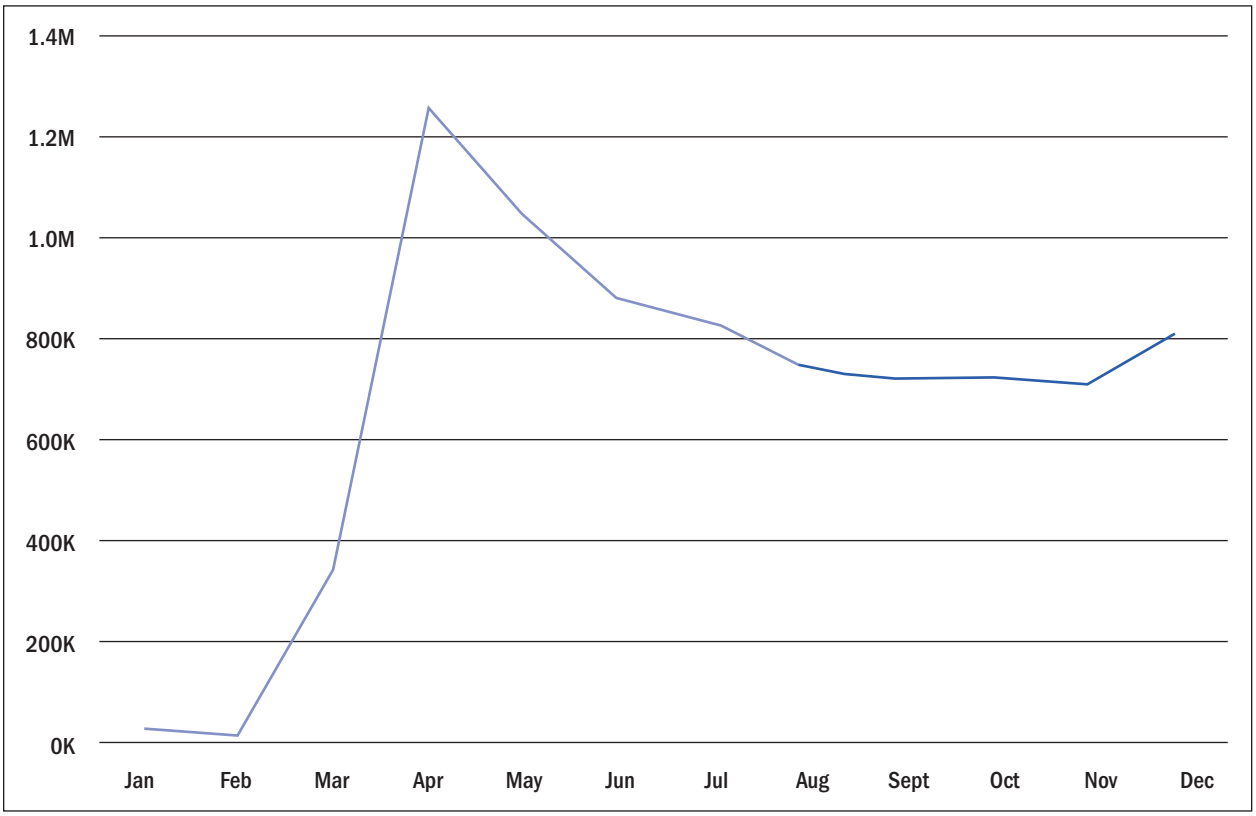


Exhibit 7: Trend in Telehealth Claims from January to December 2020. This line graph depicts the trend in telehealth claims from January to December 2020. Claims fell slightly from January to February, then increased dramatically from close to zero in February to more than 1.2 million in April. Telehealth claims fell from April to November, but remained drastically higher than the beginning of the year. Claims increased slightly again in December, ending the year with around 800,000 telehealth claims.

MISSION STATEMENT

MISSION

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

VISION

Oversight through innovation.

CORE VALUES

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

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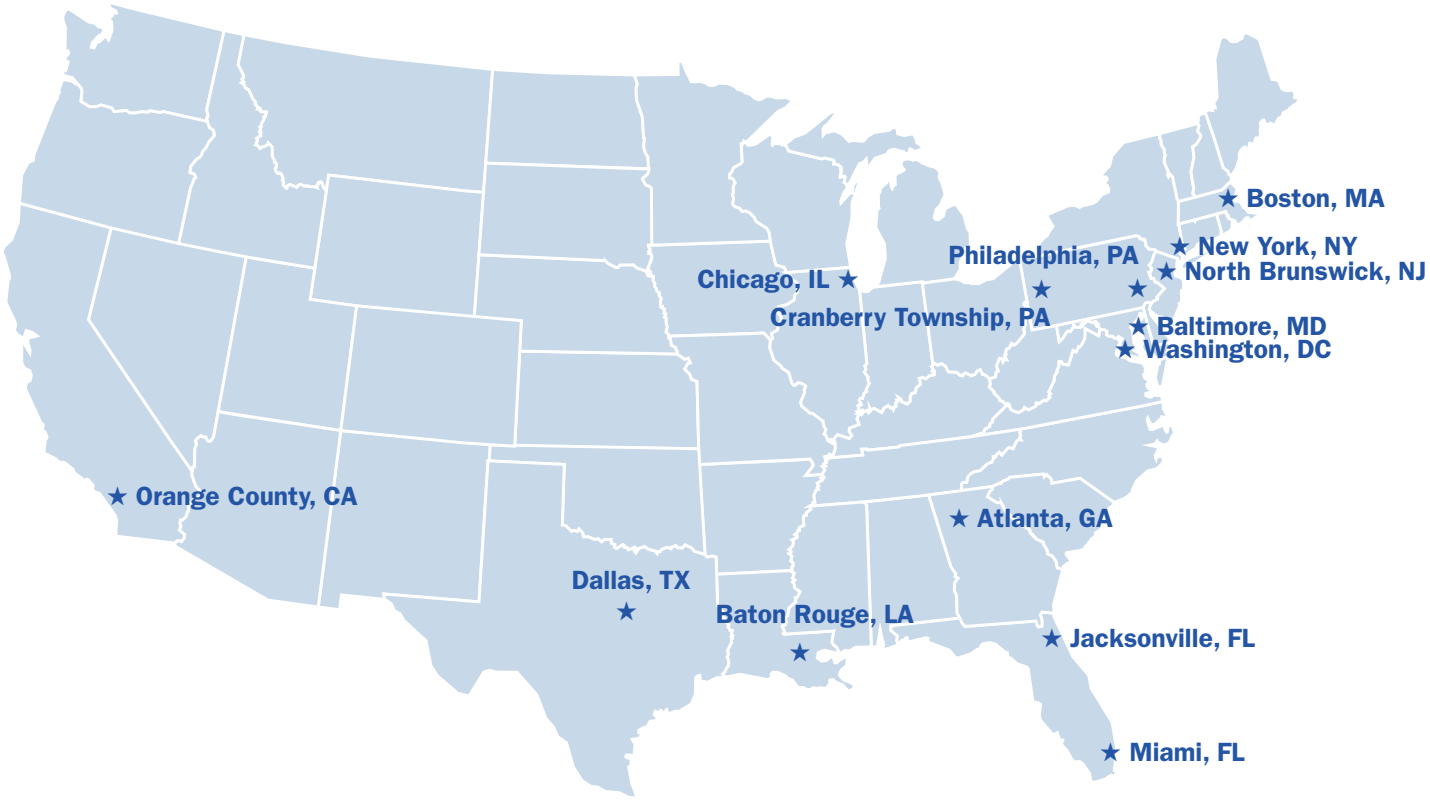
OIG OFFICE LOCATIONS



AUDIT ACTIVITIES

Health Insurance Carrier Audits

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

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

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

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

COMMUNITY-RATED PLANS

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

Similarly Sized Subscriber Group Audits

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

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

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

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

Medical Loss Ratio Audits

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

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

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act. 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 summary highlights notable audit findings for community-rated FEHBP carriers audited during this reporting period.

Humana Health Plan of Texas

Louisville, Kentucky
Report Number 1C-UR-00-19-040
December 14, 2020

Humana Health Plan of Texas (Plan) has participated in the FEHBP since 1987, and provides health benefits to FEHBP members in the San Antonio, Texas, area. The audit covered contract years 2014 and 2015. During this period, the FEHBP paid the Plan approximately $123.4 million in premiums.

Weak internal controls over the FEHBP MLR process led to inaccurate reporting of fraud reduction and tax expenses as well as reported claims totals.

We determined that portions of the MLR calculations were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM for contract years 2014 through 2015. The monetary impact of these issues was not significant enough to affect the MLRs reported to OPM.

Specifically, we found that the Plan:

- Did not report allowable fraud reduction expenses on its MLR submissions;
- Incorrectly excluded certain taxes and fees from the premium on its MLR submissions;
- Lacked adequate internal controls and oversight to update contract rates and fees in its claims processing system;
- Could not incorporate the results of provider settlements related to medical claims overpayments into the MLR submissions;
- Did not apply applicable copayments for lab and imaging procedures performed by independent lab and imaging facilities and primary care providers; and
- Did not price pharmacy claims for a unique prescription drug using the correct copayment.

The Plan agreed to all of the above findings.

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 six final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP. These six final audit reports contained recommendations for the return of over $7.69 million to the OPM-administered trust fund.

Blue Cross Blue Shield Service Benefit Plan Audits

The BlueCross BlueShield Association (BCBS Association), on behalf of 64 participating plans

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

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

The following are summaries of five recent BCBS audits that are representative of our work

BlueCross BlueShield of Michigan

Detroit, Michigan
Report Number 1A-10-32-20-027
February 12, 2021

Our audit of the FEHBP operations at BCBS of Michigan (BCBS of MI) covered the plan's administrative expense charges, cash management activities and practices, and fraud and abuse program activities. We questioned $2,648,338 in administrative expense overcharges, cash management activities, and lost investment income. Our most significant finding was that BCBS of MI overcharged the FEHBP $2,513,339 for Federal income taxes related to the Affordable Care Act health insurance provider fees.

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

BlueCross BlueShield of Louisiana

Baton Rouge, Louisiana
Report Number 1A-10-07-20-028
February 12, 2021

Our audit of the FEHBP operations at BCBS of Louisiana (BCBS of LA) covered the plan's administrative expense charges and cash management activities and practices. The objectives of our audit were to determine whether BCBS of LA charged administrative expenses and handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and Federal regulations.

We questioned $135,194 in administrative expense overcharges and lost investment income. The BCBS Association and BCBS of LA agreed with all of the questioned amounts. As part of our review, we verified that BCBS of LA subsequently returned these questioned amounts to the FEHBP.

The audit disclosed no findings pertaining to the plan's cash management activities and practices related to FEHBP funds. Overall, we determined that BCBS of LA handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and Federal regulations.

Audit of Claims Processing and Payment Operations at Highmark Blue Cross Blue Shield for the period January 1, 2017, through August 31, 2019

Report Number 1A-10-31-20-006
December 14, 2020

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

Our audit identified the following:

- The Plan paid 25 claims incorrectly, totaling $72,308, due to provider network status issues; and
- The Plan paid two claims incorrectly, totaling $28,956, because it did not follow its procedures for the pricing of pharmaceuticals.

We also recommended a program improvement related to member notification of debarred providers on the explanation of benefits (EOB) statements. Specifically, we recommended the Association move to auto-generating messages on its EOB statements to remove the potential for human errors.

This final report included three monetary and three procedural recommendations. OPM has closed one monetary and all three procedural recommendations. Two monetary recommendations remain open.

Global Audits

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

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

Audit of Duplicate Claim Payments at all Blue Cross Blue Shield Plans for the period July 1, 2016, through July 31, 2019

Report Number 1A-99-00-19-002
February 12, 2021

This audit's objectives were to determine whether the local BCBS Plans (Plans) charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with OPM. Specifically, our objective was to determine whether the Plans complied with the contract's provisions relative to duplicate claim payments.

Our audit identified the following:

- The Plans paid 668 claims incorrectly, totaling $1,444,709 in net overcharges, due to processors overriding claims originally denied as duplicate payments;
- The Plans paid 129 claims incorrectly, totaling $296,917 in net overcharges, due to provider billing coding variations that allowed payments of duplicate claims;
- The Plans paid 50 claims incorrectly, totaling $150,364 in net overcharges, due to the local

BCBS plan's claim system and/or the Association failing to detect the duplicate payment;

- The Plans paid 59 claims incorrectly, totaling $143,865, due to inter-plan duplicate payment errors. These errors are caused when a claim, or portion of a claim, is paid by two different local BCBS plans; and
- The Plans paid 80 claims incorrectly, totaling $60,045 in net overcharges due to various pricing errors other than duplicate payment errors.

This final report included two monetary and six procedural recommendations. OPM is currently working with the Association to resolve and close these recommendations. Consequently, all eight recommendations remain open.

Audit of Enrollment at All Blue Cross Blue Shield Plans for Contract Years 2018-2019

Report Number 1A-99-00-20-018
March 12, 2021

This audit's objectives were to determine whether the local BCBS Plans charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the BCBS Association's contract with OPM. Specifically, our objective was to determine whether the BCBS Plans complied with the contract's provisions relative to claims paid for ineligible enrollees.

This report showed a significant reduction in the amount of enrollment errors (from $7.3 million for a 32-month audit period to $412,570 for a 24-month period) we identified and reported in our previous audit, covering contract years 2018–2019. We commended the Association for corrective actions taken since the last global enrollment audit to reduce the number of errors identified.

Our current audit identified the following:

- We found 42 members who were ineligible for coverage at the time services were rendered. These members incurred 436 claims (medical and pharmacy), totaling $412,570, which were erroneously paid due to retroactive enrollment updates or system errors;
- Included in the 42 members above were 13 members, identified as former spouses or ineligible family members, who on average used benefits for 10 years after they were deemed ineligible. Once identified, the local BCBS plans failed to identify these as cases of potential fraud, waste, and abuse and refer them to their Special Investigations Units.

This final report included two monetary and three procedural recommendations. OPM is currently working with the Association to resolve and close these recommendations. Consequently, all five recommendations remain open.

Employee Organization Plans

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

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

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

Experience-Rated Comprehensive Medical Plans

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

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

CareFirst BlueChoice, Inc.

Owings Mills, Maryland
Report Number 1D-2G-00-20-003
November 30, 2020

Our audit of the FEHBP operations at CareFirst BlueChoice, Inc. (Plan) covered health benefit refunds and recoveries, including pharmacy and medical drug rebates, and administrative expense charges. We also reviewed the Plan's cash management activities and practices related to FEHBP funds as well as the Plan's fraud and abuse program.

We questioned $2,302,023 in health benefit refunds and recoveries, administrative expense overcharges, and lost investment income. We also identified a procedural finding regarding the Plan's fraud and abuse program. Our most significant findings were that the Plan had not returned 44 health benefit refunds, totaling $2,095,866, to the FEHBP. Due to concerns with the Plan's FEHBP health benefit refunds, we expanded our review of refunds, and we plan to issue a supplemental final report with the results of this expanded review.

The Plan agreed with all of the questioned amounts as well as the procedural finding for the fraud and abuse program. As part of our review, we verified that the Plan subsequently returned these questioned amounts to the FEHBP.

Health Care Data Analytics

As discussed in the COVID-19 section of this semiannual report, we participated in the Pandemic Response Accountability Committee's (PRAC's) recent analysis of COVID-19 testing efforts in Federal health care programs. That work relied on health care data analytics provided by the six Inspectors General participating in the PRAC's Health Care Subgroup. Building on that project, we are establishing our own health care data analytics team in our Office of Audits. That team's first project involved analysis of avoidance or delay of preventive care in the FEHBP. A summary of the data brief issued to OPM resulting from this effort is below.

Downward Trends in FEHBP Member's Use of Preventive Care Services Caused by the COVID-19 Pandemic

Report Number 1K-99-00-20-046
Original Issue Date: December 21, 2020
Corrected Report Issue Date: January 6, 2021

The purpose of this data brief was to present to OPM our concerns with downward trends we observed in our health care claims data related to preventive care services utilized by a selected section of FEHBP participants during the COVID-19 pandemic. Specifically, we focused our review on claims incurred and paid from January through August of 2020 and compared this data to the same time period in 2019.

The data brief offered OPM and the FEHBP participating health insurance carriers insight into how COVID-19 affected a large portion of the FEHBP population and was intended to encourage discussions regarding actions that may need to be

considered to offset the potential impact to the program and its members.

The data brief made three procedural recommendations:

- That OPM engage with its FEHBP carrier partners to assess the potential impact of the decreased preventive care utilization trends on their member populations and formulate recommendations and a plan for agency action based on the best interests of the Government, the FEHBP, and its enrollees;
- That OPM work with FEHBP carriers to develop and implement creative solutions that will encourage FEHBP members to safely make use of preventive care services; and
- That OPM work with FEHBP carriers to develop plans to help mitigate potential long-term effects of these downward trends on future premium rates.

All three recommendations remain open.

As part of the COVID-19 section of this semiannual report, we expanded our analysis of preventive care trends to include September through December 2020. The results of our analysis can be found in the COVID-19 section of this semiannual report.

Information Systems Audits

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

Our audit universe encompasses all 53 OPM-owned information systems as well as the 74 information systems used by private sector entities that contract with OPM to process Federal data. We issued nine IT system audit reports during the reporting period. The selected notable reports are summarized below."

Audit of the Information Technology Security Controls of the U.S. Office of Personnel Management's Agency Common Controls

Washington, D.C.
Report Number 4A-CI-00-20-008
October 30, 2020

The agency common controls are controls that are developed, implemented, assessed and monitored by the agency and are inherited by all of OPM's systems. The Common Security Control Collection (CSCC) lists all of the agency common controls. Our audit of the agency common controls listed in the CSCC determined that:

- Documentation assigning roles and responsibilities for the governance of the CSCC does not exist;
- Inconsistencies in the risk assessment and reporting of deficient controls were identified in the most recent assessment results documentation of the CSCC;
- Weaknesses identified in an assessment of the CSCC were not tracked through a plan of actions and milestones;
- Weaknesses identified in an assessment of the CSCC were not communicated to the Information System Security Officers, System Owners, or Authorizing Officials of the systems that inherit the controls; and
- We tested 56 of the 94 controls in the CSCC. Of the 56 controls tested, 29 were either partially satisfied or not satisfied. Controls are considered satisfied when they are fully implemented in accordance with standards issued by the National Institute of Standards and Technology (NIST).

Federal Information Security Modernization Act Audit for Fiscal Year 2020

Washington, D.C.
Report Number 4A-CI-00-20-010
October 30, 2020

The Fiscal Year (FY) 2020 Federal Information Security Modernization Act (FISMA) Inspector General (IG) reporting metrics use a maturity model evaluation system derived from NIST's Cybersecurity Framework. The Cybersecurity Framework is comprised of eight "domain" areas and the modes (i.e., the number that appears most often) of the domain scores are used to derive the agency's overall cybersecurity score. In FY 2020, OPM's cybersecurity maturity level was measured as "2 – Defined."

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

- **Risk Management** — OPM has defined an enterprise-wide risk management strategy through its risk management council. OPM is working to implement a comprehensive inventory management process for its system interconnections, hardware assets, and software;
- **Configuration Management** — OPM continues to develop baseline configurations and approve standard configuration settings for its information systems. The agency is also working to establish routine audit processes to ensure that its systems maintain compliance with established configurations;
- **Identity, Credential, and Access Management (ICAM)** — OPM is continuing to develop its agency ICAM strategy, and acknowledges a need to implement an ICAM program. However, OPM still does not have sufficient processes in place to manage contractors in its environment;
- **Data Protection and Privacy** — OPM has implemented some controls related to data protection and privacy. However, there are still resource constraints within OPM's Office of Privacy and Information Management that limit its effectiveness;
- **Security Training** — OPM has implemented a security training strategy and program and has performed a workforce assessment, but is still working to address gaps identified in its security training needs;
- **Information Security Continuous Monitoring** — OPM has established many of the policies and procedures surrounding continuous monitoring, but the agency has not completed the implementation and enforcement of the policies. OPM also continues to struggle to conduct security controls assessments on all of its information systems;
- **Incident Response** — OPM has implemented many of the required controls for incident response. Based upon our audit work, OPM has successfully implemented all of the FISMA metrics at the level of "consistently implemented" or higher; and
- **Contingency Planning** — OPM has not implemented several of the FISMA requirements related to contingency planning. The agency continues to struggle with both maintaining its contingency plans and with conducting contingency plan tests on a routine basis.

Audit of the General and Application Controls at the Health Alliance Plan of Michigan

Troy, Michigan
Report Number 1C-52-00-20-011
November 30, 2020

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

- HAP utilizes network connection guidance from its parent company; however, it does not have a formal firewall policy and does not perform routine firewall configuration audits;
- HAP has conducted disaster recovery plan tests; however, a business continuity plan test has not been conducted; and
- HAP has adequate controls over the application configuration management process.

We also observed IT security control weaknesses in other areas, and communicated those to HAP officials in separate correspondence. For security reasons, we did not publicly release the details of those weaknesses.

Audit of the Information Systems General and Application Controls at Capital BlueCross

Harrisburg, Pennsylvania
Report Number 1A-10-36-20-032
February 21, 2021

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

- CBC has adequate controls over security management;
- CBC has adequate logical and physical access controls;
- CBC has adequate network security controls in place, such as encryption to protect sensitive data and data loss prevention. However, controls could be improved in several related areas;
- CBC maintains approved security configuration standards but needs to take corrective action to improve some related controls;
- CBC has adequate controls over contingency planning; and
- CBC has adequate controls over its claims adjudication process.

Internal Audits

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

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

OPM's Retirement Services Disability Process

Washington, D.C.
Report Number 4A-RS-00-19-038
October 30, 2020

Our auditors completed a performance audit of OPM's Retirement Services disability process. As defined in Title 5 of the United States Code, retirement disability is a benefit to protect employees no longer able to provide "useful and efficient service" due to a medical condition. Retirement Services is responsible for managing disability retirement benefits, including approving or disapproving disability applications for Federal Government agencies and determining benefit amounts.

The objectives of our audit were to (1) determine if OPM's Retirement Services and Support, Claims I, and the Appeals groups are following laws, regulations, policies, and procedures; (2) ensure management is providing oversight reviews; and (3) determine if controls are in place to ensure staff are trained to perform their duties.

We determined that OPM's Retirement Services office correctly processed Disability Claims, in accordance with Chapter 83, Subchapter III, Civil Service Retirement System (CSRS) and Chapter 84, Federal Employees Retirement System (FERS) of Title 5 of the United States Code (U.S.C.) and OPM's CSRS/FERS Handbook. However, we identified four areas where Retirement Services' controls over its disability process should be strengthened. Specifically:

- Retirement Services lacks the proper documentation to verify training for the Boyers Disability Section, Appeals, and Claims I staff;
- Retirement Services could not support that it properly engaged in what is known as the Medical Call-ups process—the requirement to annually reevaluate cases initially approved for disability retirement on a temporary basis until the annuitant reaches age 60;
- Claims I Quality Assurance Reviews were incomplete and not documented; and
- We analyzed 61 out of 6,956 Retirement Disability Receipts for FY 2019 and identified issues with processing timeliness and case tracking.

In response to the eight recommendations contained in our final report, Retirement Services partially concurred with one recommendation and concurred with the remaining seven.

OPM's Consolidated Financial Statement Audits

The Chief Financial Officers Act of 1990 (P.L. 101-576) requires OPM's IG or an independent external auditor, as determined by the IG, to audit the

agency's financial statements in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. OPM contracted with Grant Thornton LLP, an independent certified public accounting firm, to audit the consolidated financial statements as of September 30, 2020 and September 30, 2019. The contract required that the audit be performed in accordance with generally accepted government auditing standards (GAGAS) and the U.S. Office of Management and Budget (OMB) Bulletin No. 19-03, *Audit Requirements for Federal Financial Statements.*

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

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

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

In connection with the audit contract, we reviewed Grant Thornton's report and related documentation and made inquiries of its representatives regarding the audit. To fulfill our audit responsibilities under the Chief Financial Officers Act for ensuring the quality of the audit work performed, we conducted a review of Grant Thornton's audit of OPM's Fiscal Year 2020 Consolidated Financial Statements in accordance with *Government Auditing Standards*. Specifically, we:

- Provided oversight of—and technical advice and general liaison services to—Grant Thornton auditors;
- Ensured that audits and audit reports were completed timely and in accordance with the requirements of GAGAS, OMB Bulletin 19-03, and other applicable professional auditing standards;
- Documented oversight activities and monitored audit status;
- Reviewed responses to audit reports and reported significant disagreements to the audit follow-up official per OMB Circular No. A-50, Audit Follow-up;
- Coordinated issuance of the audit report; and
- Performed other procedures we deemed necessary.

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

OPM's FY 2020 Consolidated Financial Statements

Washington, D.C.
Report Number 4A-CF-00-20-024
November 13, 2020

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

- The consolidated balance sheets as of September 30, 2020, and 2019;
- The related consolidated statements of net cost, changes in net position, and the combined

statements of budgetary resources for the years then ended;

- The related notes to the consolidated financial statements;
- The individual balance sheets of the Retirement, Health Benefits, and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2020, and September 30, 2019;
- The related individual financial statements of net cost, changes in net position, and budgetary resources for the years then ended; and
- The related notes to the individual financial statements.

Grant Thornton reported that OPM's consolidated financial statements and its Programs' individual financial statements as of and for FYs ended September 30, 2020, and September 30, 2019, were presented fairly in all material respects, and in conformity with U.S. Generally Accepted Accounting Principles Grant Thornton's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

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

Information Systems Control Environment continues to be a material weakness reported in FY 2020

Information Systems Control Environment—During FY 2020, deficiencies noted in FY 2019 continued to exist, and Grant Thornton's testing identified similar control issues in both design and operation of key controls. These deficiencies continue to exist because of one, or a combination, of the following:

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

The information system issues identified in FY 2020 included repetitive conditions consistent

with prior years, as well as new deficiencies. The deficiencies in OPM's information systems control environment are in the areas of Security Management, Logical Access, Configuration Management, and Interface/Data Transmission Controls. In the aggregate, these deficiencies are considered to be a Material Weakness. OPM concurred with the findings and recommendations reported by Grant Thornton.

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

The National Background Investigations Bureau's Backlog of Background Investigation Cases and the Effectiveness of the Quality Assurance Process

Washington, DC
Report Number 4A-IS-00-18-042
January 21, 2021

Our auditors completed a performance audit on the status and mitigation of OPM's former National Background Investigations Bureau's (NBIB)[2] backlog of background investigation cases and the effectiveness of NBIB's quality assurance process. On July 2, 2018, we held an entrance conference with relevant NBIB personnel to officially begin the audit process. Our audit fieldwork was conducted from February 28 through July 18, 2019, at OPM's headquarters located in Washington, D.C. and NBIB field offices located in Fort Meade, Maryland, and Boyers, Pennsylvania.

During our audit, NBIB stated that our audit conclusions and recommendations were not important, as the background investigation function would soon be transferring to the Department of Defense (DoD). Our audit focused on the plan to reduce the backlog of cases, NBIB's compliance with reporting requirements, and the quality review process. As was discussed with NBIB officials numerous times, these areas did not become irrelevant or insignificant simply because the background investigation function was, at some point in the future, going to be transferred to DoD effective on October 1, 2019 and be named the Defense Counterintelligence and Security Agency (DCSA).

The objectives of our audit were to determine if (1) the reported backlog of background investigation cases was accurate and to perform a review of the backlog mitigation plan; (2) NBIB Federal and contractor staff were following procedures for the case oversight process; and (3) NBIB Federal and contractor staff had controls in place to ensure personnel were trained toperform their duties. Ultimately, the goal of this audit, and any potential recommendations, was to focus on issues that would be relevant, regardless of whether the program was with OPM or DoD.

We determined that NBIB reported on its background investigations backlog and submitted a mitigation plan to Congress, as required by the Securely Expediting Clearances Through Reporting

[2] On October 1, 2019, NBIB transferred to DoD and is now called DCSA. Therefore, we will refer to them as NBIB for events that occurred prior to October 1, 2019, and DCSA for events occurring after that date.

Transparency Act of 2018. However, we identified three areas where NBIB's (now DCSA's) controls should be strengthened. Specifically:

- NBIB could not provide sufficient and appropriate documentation to validate data included in the reports. As a result, we were unable to validate the increase/decrease of the reported inventory of cases;
- NBIB and its contractors did not follow policies and procedures for case processing oversight in the following areas – check rides, telework, reopen cases, deficient cases, and other investigative quality checks; and
- NBIB did not provide sufficient documentation to support that 36 of the 379 Investigations Case Analysts tested were properly trained to perform their duties. In addition, none of the 65 Investigative Assistants received formal training.

Throughout the audit, NBIB closely monitored OIG personnel, imposing new and unique requirements that appeared to have no purpose other than to impede our audit process. In response to our draft report, DCSA stated that even if the findings were valid and they failed to implement the recommendations, there would be no negative impact. This statement is representative of NBIB/DCSA's attitude toward this audit. The belief that the audit was not important or significant permeated throughout all interactions with NBIB's points of contact (POCs), to the point that they were a roadblock to our ability to conduct meetings and gather information from the relevant NBIB subject matter experts, causing numerous delays. This occurred in spite of the fact that, as previously stated, we explained on multiple occasions that our audit objectives were selected because the areas would still apply to NBIB/DCSA's operations, even after NBIB's move to DoD.

We submitted a draft audit report to the former NBIB Director and subsequently became the former Acting Director of DCSA, in order to elicit comments on our findings, conclusions, and recommendations. We note that DCSA did not agree with the findings presented in our report, not because the findings were inaccurate or lacked merit, but rather based on their belief that the OPM OIG failed to follow proper audit procedures. However, all findings, conclusions, and recommendations were developed based on information provided by the NBIB's subject matter experts, during meetings and walkthroughs, and with documentation provided by NBIB's POCs. Furthermore, we developed audit steps and conducted our audit based on laws (e.g., A U.S. Government Accountability Office Standards), and NBIB guidance and instructions (e.g., Standard Operating Procedures, contracts, etc.) obtained during our audit survey phase. The bases for the findings presented in our final report are the laws, regulations, and guidance which govern the audit, as well as the answers and documentation (or lack thereof) received from NBIB. We conducted this performance audit in accordance with GAGAS as established by the Comptroller General of the United States. Our responses to DCSA's non-concurrence with each of our findings can be found in the Audit Findings and Recommendations section of the final report located on our website at https://www.opm.gov/our-inspector-general/publications/reports/2021/4a-is-00-18-042.pdf.

While we were able to complete our audit and present the results based on our review and testing of the information provided, the entire process

was significantly impacted and delayed by the POCs' unwillingness to cooperate. A key factor in making an audit and its recommendations useful is timeliness. We obviously did not issue the final audit report in a timely manner, but point to the delays caused by NBIB as a primary reason for this. Our final audit report was issued to the Acting IG for DoD and the Director of DCSA and due to NBIB's transfer to DoD, we do not consider OPM to be responsible for resolution of recommendations in this report.

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 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 to ensure monies donated by Federal employees and annuitants are properly handled and disbursed to charities according to the designations of contributing employees and annuitants.

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

Audit of the U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs

Report Number 4A-HI-00-19-007
October 30, 2020

We completed a performance audit of OPM's administration of Federal employee insurance programs. Our audit consisted of a review of OPM's Healthcare & Insurance Division and its groups that administer health care and insurance benefits, which include Audit Resolution and Compliance (ARC), Federal Employees Health Benefits (FEHB), the FEDVIP, Life and Ancillary Benefits, and the Performance Improvement Group. The objective of the audit was to determine whether OPM's internal controls and program requirements were adequate to efficiently administer health care and insurance benefits to Federal employees, annuitants, and their dependents for operating year 2018.

We determined OPM needs to strengthen internal controls and program requirements within its ARC, FEHB, and FEDVIP Groups to efficiently administer health care and insurance benefits to Federal employees, annuitants, and their dependents. No deficiencies were identified during our review of OPM's Life and Ancillary Benefits or Performance Improvement Groups. Some of our audit results are summarized as follows:

- OPM has unauthorized contracting officers (as a result of incomplete training records) and unofficial contracting officer representatives administering health care and insurance benefit contracts;
- OPM does not have sufficient controls in place to prevent ineligible family members from enrolling in the FEHBP or the FEDVIP;
- OPM lacks a formal fraud, waste, and abuse and debarment/suspension requirement for FEDVIP carriers; and

- OPM needs to improve FEDVIP by establishing standardized performance measures with penalties.

OPM lacks sufficient controls to ensure that only eligible family members are enrolled in the FEHBP

Audit of the Federal Flexible Spending Account Program As Administered by WageWorks, Inc.

Report Number 1N-0A-00-20-023
February 21, 2021

The OIG completed a performance audit of FSAFEDS as administered by WageWorks, Inc. (WageWorks). Our audit included reviews of WageWorks' administrative expenses, cash management, claim benefit payments, and performance guarantees during the period of September 1, 2016, through December 31, 2018. The objective of the audit was to determine whether costs charged to the FSAFEDS and services provided to its participants were in accordance with the terms of the contract and Federal regulations.

WageWorks complied with its contract and Federal regulations.

Based on our audit reviews, we did not identify any audit findings or recommendations. As a result, we determined costs charged to the FSAFEDS program and services provided to FSAFEDS participants complied with the terms of its contract and Federal regulations for the scope of our audit.

ENFORCEMENT ACTIVITIES

Investigative Activities

The Office of Investigations' mission is to protect Federal employees, annuitants, and their eligible beneficiaries from fraud, waste, abuse, and mismanagement in OPM programs. We pursue this mission by conducting criminal, civil, and administrative investigations related to OPM programs and operations. OPM annually disburses more than $140 billion in benefits through CSRS, FERS, FEHBP, and FEGLI, which are paid from OPM-administered trust funds that collectively hold over $1 trillion in assets. These programs cover more than 8 million current and retired Federal civilian employees and eligible family members. Our investigations safeguard OPM's financial and program integrity and protect those who rely on OPM programs. The Office of Investigations prioritizes investigations into allegations of harm against those reliant on OPM programs, the substantial loss of taxpayer dollars, and agency program weaknesses that allow fraud, waste, and abuse.

In this Semiannual Report to Congress, we present both the successes of our Office of Investigations and obstacles we face in protecting OPM programs and beneficiaries from potential patient harm, fraud, waste, abuse, and mismanagement.

The OPM OIG Office of Investigations has been challenged, as many OIGs have, by the COVID-19 pandemic. OPM OIG criminal investigators and investigative support staff met the unprecedented operational complexities with resiliency and adapted to maintain effective oversight of OPM programs and to protect OPM beneficiaries. Because the COVID-19 pandemic is a health crisis, we anticipated that bad actors would attempt to take advantage of the pandemic. We have prioritized investigating allegations of fraud, waste, and abuse cases against FEHBP enrollees and the Trust Fund that involve COVID-19 pandemic, especially in cases of potential patient harm. We also continued our essential investigative operations as part of our oversight mission.

In **FY 2020** OPM reported that the FEHBP paid more than **$25.18 million** in improper payments. OPM also reported that they paid more than **$299.04 million** in improper payments related to its Federal Retirement Programs.

While adapting operations to conduct investigative activities safely, we engaged with the increased potential for fraud, waste, or abuse created by the COVID-19 pandemic and the other preexistent challenges to OPM programs, including the opioid epidemic.

OPM has recognized that the COVID-19 pandemic has affected all Federal employees and their families, but especially persons suffering from mental and behavioral health conditions such as depression, anxiety, or substance use disorders. The OIG's Office of Investigations pursues cases against bad actors who prey on those seeking treatment for issues exacerbated by the COVID-19 pandemic or

FEHBP enrollees and their eligible dependents who generally are defrauded in seeking health care for themselves or their loved ones.

We also continue to face program challenges that negatively affect OPM and our investigations. This particularly includes the FEHBP's continued exclusion from the Anti-Kickback Statute (AKS).

COVID-19's Impact on Investigations

In the six-month period covered by this semiannual report, we have continued to conduct investigative operations with the health and safety of our investigative staff and special agents and the public as a priority. This has included operating from a maximum telework posture at our headquarters and regional offices, taking additional health and safety measures when conducting necessary field operations, and following the guidance of the Centers for Disease Control and Prevention and OPM as necessary.

However, the COVID-19 pandemic has negatively affected some of our investigations and operations. This primarily includes:

- Reducing the ability of our special agents to travel to conduct investigative activities;
- Limiting the availability of investigative witnesses or subjects who work as health care providers in busy COVID-19-affected locations; and
- Reducing our ability to coordinate with our partners at the Department of Justice (DOJ).

Due to COVID-19, our investigations took longer than normal. We suspended our work in several cases because of the COVID-19 pandemic. Primarily, these suspended cases involved an inability to access necessary health care workers whose work involved treating patients in areas severely affected by COVID-19 or cases where we were unable to access information stored in buildings closed by the pandemic. We will resume these cases at the discretion of our partners at DOJ and when safe operations permit.

COVID-19 Potential Investigative Trends

We have received case referrals related to a variety of fraud schemes and criminal actions that involve the COVID-19 pandemic. However, we are not reporting specific cases related to COVID-19 during this semiannual reporting period. Our current investigations are ongoing through the lengthy investigative, DOJ and judicial processes regularly associated with health care fraud investigations. We have identified some fraud trends that we expect will persist as the pandemic continues, including during the nationwide vaccination campaign and continued periods of social distancing and other COVID-19 safety measures.

Fake COVID-19 cures and schemes remain a concern that we continue to monitor as we receive and review case referrals from FEHBP carriers or other leads via the OPM OIG Hotline or information from our law enforcement partners.

We also anticipate an increase in fraud, waste, and abuse investigations that relate to or in some way involve telehealth. During the pandemic, fraudsters refashioned or adapted their schemes for social distancing. The OPM OIG anticipates we will report our successes investigating more of these types of cases in future semiannual reports as the cases resolve.

FEHBP Health Care Fraud, Waste, and Abuse Investigations

The FEHBP is the largest employer-sponsored health insurance program in the world, covering about 8.2 million current Federal civilian employees, retirees, and their eligible family members. The program receives overall positive ratings from enrollees for program satisfaction. However, the program is susceptible to fraud, waste, and abuse—both from program weaknesses within the FEHBP and from the same fraud, waste, and abuse that affects the health care system at large. In recent years, approximately 80 percent of the criminal cases we investigated involved health care fraud.

Included in this Semiannual Report to Congress is our summary of a case involving direct civil action against an FEHBP health insurance carrier. This type of action is both rare and significant, and it reinforces the importance of our mission. Without oversight and the work of the Office of Investigations, both patients and the financial integrity of the FEHBP program are at risk.

FEHBP Health Insurance Carrier Agrees to Settlement After $4.62 Million Civil Fraud Discovered

In August 2017, we received a complaint from a whistleblower employed by an FEHBP carrier. The whistleblower alleged that a provider group billed services as face-to-face preventative medicine counseling services when the services provided were actually online videos and emails from unlicensed staff. Furthermore, the FEHBP health insurance carrier who used the provider group's services knew of the fraudulently represented billed claims.

Between 2017 and 2019, the FEHBP paid the provider group more than $4.62 million for services provided under procedural codes for face-to-face services. The provider group only provided services online. Our investigation uncovered that the FEHBP provider knew and attempted to hide the fraud, including by attempting to shift the costs from administrative to claims costs.

OPM relies on its contracted FEHBP insurers to provide effective coverage to beneficiaries—free from fraud, waste, or abuse

The FEHBP health insurance provider negotiated with the U.S. Attorney's Office in the Western District of Missouri for a voluntary civil settlement to resolve the allegations. Pursuant to the settlement, the FEHBP health insurance carrier repaid $5.78 million (the original $4.62 million loss, calculated with a 1.25 multiplier). Minus the 3-percent DOJ allocation, the FEHBP recovered $5.6 million.

Action against an FEHBP carrier is especially significant. OPM relies on its contracted FEHBP health insurance carriers to operate in a way that provides effective coverage to Federal employees, retirees, and their families—free from fraud, waste, or abuse. Based on our investigation, the FEHBP health insurance carrier entirely overhauled its Special Investigations Unit, the internal group that detects and reviews suspected health care fraud.

Consequences of the FEHBP's Anti-Kickback Statute (AKS) Exclusion

The Federal AKS is one of the best-known Federal fraud and abuse statutes. The AKS is a criminal statute that prohibits transactions intended to induce or reward referrals for items or services reimbursed

by Federal health care programs. It has a significant effect on business relationships in the health care, pharmaceutical, and medical device sectors.

However, the FEHBP continues to be excluded from the AKS.

Because of our exclusion from the Anti-Kickback Statute, we were unable to participate in cases with potential losses to the FEHBP Trust Fund of approximately $28 million.

We have previously discussed issues arising from this exclusion in several prior semiannual reports to Congress, and we will continue to work with Congress to address this exclusion. This period, we identified nine cases, with potential losses of approximately $28 million to the FEHBP, that we were unable to pursue because of this exclusion. For some cases, U.S. Attorney's Offices notified us that our fraud losses would be excluded before our actual loss was calculated. In those instances, we closed our case without identifying the total loss to conserve our investigative resources. The actual fraudulent cost of AKS cases we are excluded from is likely much higher.

Even in cases successfully brought by our Office of Investigations, the AKS can be an obstacle to recovering program losses. If a case involves other crimes besides AKS violations, court-ordered restitution may not be able to include losses due to the AKS. When that happens, restitution can be poorly representative of the true loss to the FEHBP.

Case Update: Travel Act Used to Prosecute Kickback, Health Care Bribery Scheme

We previously reported on a case charging multiple defendants with conspiracy to commit health care fraud and violate the Travel Act ("Pioneering Use of the Travel Act in Kickback, Health Care Bribery Scheme," Semiannual Report to Congress for October 1, 2018, to March 31, 2019.) The case involved a physician-owned surgical hospital that paid bribes and kickbacks to surgeons in exchange for patient referrals. The bribes and kickbacks were concealed as "co-marketing agreements." During 3 years of the scheme, the FEHBP was defrauded of more than $18.15 million.

We discussed these indictments in our previous Semiannual Report to Congress because the use of the Travel Act (predicated upon violations of Texas's commercial bribery law) was at the time a novel way to combat health care fraud. Now, we report that our investigative effort to use the Travel Act as part of a health care fraud investigation was ultimately successful. In addition to previous sentencings outside of the semiannual reporting period, 11 individuals were sentenced on March 17 and 18, 2021. Together, these judicial actions represent more than 60 years of sentenced prison time related to this fraud. The FEHBP will receive $840,005 in restitution.

Fraud Involving Diabetic Testing Supplies Leads to 15 Settlements

In April 2015, we received a *qui tam* referral that alleged a pharmacy provider and its subsidiary pharmacies engaged in a scheme to inaccurately fill prescriptions and submit false claims for reimbursement for diabetic testing and treatment supplies. The total loss to OPM exceeded $9.5 million.

In addition to the financial loss, this case risked patient harm: as part of the fraud scheme, patient prescriptions were transferred from their local pharmacy to a mail order pharmacy. Patients did not know of and did not consent to the changes. The changes prevented patients from obtaining their regular refills of diabetic test strips and risked leaving members with generic, unfamiliar diabetic testing meters and strips. Inaccurate use of diabetic testing supplies can be dangerous for patients who rely on the tests to monitor their blood sugar to make informed daily health choices.

Over the past year, we have entered into civil settlements with 15 different entities that participated in this fraud, with the dates and recoveries shown below:

Settlement Date	OPM Net Recovery
March 27, 2020	$1,493
April 6, 2020	$3,223
April 6, 2020	$4,959
April 6, 2020	$8,582
May 27, 2020	$17,357
May 27, 2020	$17,357
May 27, 2020	$457,102
May 27, 2020	$55,545
June 24, 2020	$14,878
June 30, 2020	$99,188
July 2, 2020	$54,670
July 20, 2020	$17,925
October 2, 2020	$24,797
October 2, 2020	$24,797
October 2, 2020	$49,272
Total	**$851,145**

The Ongoing Opioid and Substance Use Disorder Crisis

The nationwide opioid and drug abuse crisis, also known as the Opioid Epidemic appears to have worsened as the public endures the COVID-19 pandemic. While much of the opioid crisis involves the use of illegal fentanyl and other opioids not procured from medical providers, prescriptions can still be a vector for fraud, waste, and abuse within the FEHBP. Furthermore, ancillary fraud schemes, such as those affecting recovery and treatment programs, harm FEHBP beneficiaries and the program with significant costs.

Fraud, waste, and abuse related to treatment or at substance abuse disorder treatment centers and sober homes remains an immediate and pressing concern. These schemes are costly and often endanger the health of patients seeking treatment. We continue to prioritize these cases as part of our mission to investigate allegations of patient harm.

Three Plead Guilty to Naloxone Fraud Scheme

In October 2016, we received a case referral from an FEHBP health insurance carrier alleging that a provider group had suspicious billing patterns, particularly for high-dollar reimbursement medications from several manufacturers. This billing pattern can potentially signal an improper or fraudulent relationship between health care entities.

The at-issue medications included a drug that contains naloxone, which is used in treating acute opioid overdose. Other medications with suspiciously high billing amounts included non-opioid pain relievers.

Three individuals were charged and pled guilty in September 2020 to conspiracy to offer and pay health care kickbacks. In October and November 2020, the three individuals pled guilty in the U.S. District Court for the Eastern District of Virginia to charges including health care fraud.

On March 5, 2021, two of the three individuals were sentenced. The first individual received 36 months

of imprisonment, 3 years of supervised release, and was ordered by the court to pay $5.1 million in restitution. The FEHBP will receive $980,758. The second individual received 12 months and 1 day of imprisonment, 2 years of supervised release, and a $100 special assessment fee. We anticipate further judicial action in this case.

Retirement Annuity Fraud Investigations

Our Office of Investigations investigates various forms of fraud, waste, and abuse that affect the OPM retirement programs. Wrongdoing that abuses OPM Retirement Programs, particularly FERS and CSRS, is costly and can harm annuitants who rely on OPM programs as an important source of their income in retirement. As part of our mission to protect OPM annuitants, we have previously worked with DOJ liaisons focused on elder abuse.

The OPM OIG can also help beneficiaries or their families receive duly earned benefits, particularly when benefits are suspended because OPM has reason to believe an annuitant is deceased but has not confirmed the death. During this semiannual reporting period, our Investigative Support Group's proactive investigative work located death records for several annuitants, allowing cases to be changed to a "dropped for death" status. In some instances, this status change allowed the deceased annuitant's beneficiaries to receive life insurance payments or other accrued annuities. The proactive projects our Investigative Support Operations group conducts are an essential part of our oversight of the OPM Retirement Programs.

During this semiannual reporting period, OPM received $1,412,221 in recoveries based on our investigations of fraud within OPM's Retirement Programs

Representative Payees are individuals entrusted with the task of receiving and using OPM annuity payments on behalf of an annuitant who is incapable of managing their own OPM benefits. Representative Payee fraud is a form of fraud and abuse that harms those reliant on OPM annuity payments. We continue to present for prosecution cases made possible by the bipartisan Representative Payee Fraud Prevention Act of 2019. This law closed a loophole that limited prosecution of some Representative Payees who stole annuity payments from Federal retirees or survivor annuitants. These cases are increasingly part of our investigative portfolio and an essential part of our mission to protect OPM beneficiaries and programs.

OPM Annuitant Killed in Elder Abuse Crime

In June 2016, a person who was an FEHBP enrollee and OPM annuitant died of an opioid overdose. The local police department investigated the case as a homicide. The investigative suspect was the caretaker of the decedent.

The FEHBP had paid $3,861 in medical claims related to the opioids involved in the death. OPM also paid $26,461 in post-death annuity payments in an OPM annuity. We provided this information to the Riverside County District Attorney's Office. That office informed us that the annuity might have been part of a potential financial motive to the homicide.

On November 19, 2020, the caretaker was found guilty of homicide, elder abuse, identity theft, perjury, making false statements, and aggravated white collar crime. On January 21, 2021, the

caretaker was sentenced to 30 years in prison for the murder of the Federal annuitant and stealing from the annuitant.

Theft of Public Money Guilty Plea After Unreported Annuitant Death

In March 2019, our Investigative Support Operations group identified an obituary for an OPM survivor annuitant who was deceased but still receiving an annuity from OPM. The annuitant's March 2014 death was never reported to OPM. The agency continued to make payments and ultimately paid $199,032 in improper annuity payments and an additional $40,841 in FEHBP premiums. The improper payments totaled $239,873.

We investigated an individual related to the deceased survivor annuitant for theft of the overpayments OPM made. A criminal information was filed in September 2020 in the U.S. District Court for the Southern District of Ohio charging two counts of theft of public money. The subject of our investigation pled guilty to the charge on November 2, 2020. As part of the plea agreement, the individual will pay $257,547 in restitution, of which $199,032 will be returned to OPM.

Eighteen Years of Stolen CSRS Payments Ends With Guilty Plea

In April 2019, we received a referral from the Retirement Services program office regarding potential fraud involving a CSRS survivor annuitant whose death was not reported to OPM. The annuitant had died in April 2000, but OPM continued depositing monthly annuity payments until October 2018. Our investigation found one of the annuitant's relatives was stealing the annuity for their own use.

Over the 18 years that the theft occurred, OPM made $105,761 in improper payments. The agency was able to recover $19,401 through the Treasury reclamation process through monthly offsets, but it was not the money in the survivor annuitant's bank account.

On January 4, 2021, in the U.S. District Court for the Eastern District of Virginia, the subject of our investigation was charged by criminal information for theft of Government money. On February 9, 2021, the subject of our investigation pled guilty to the charge. Further judicial action related to sentencing is expected in this case.

Investigative Updates Related to Legacy NBIB Fraud, Waste, and Abuse Cases

On October 1, 2019, the Federal Government's background investigative function transferred from OPM to the DoD, changing from NBIB to DCSA. Previously, our Office of Investigations had entered into an agreement with DoD's Defense Criminal Investigative Services (DCIS) wherein our office would provide investigative services for fraud, waste, or abuse affecting legacy background investigations, specifically cases opened while the background investigative function operated under OPM.

However, that agreement was ended, and OPM is no longer being reimbursed for investigative costs for legacy NBIB investigations. Therefore, we have closed almost all of our cases (except as noted below) related to allegations of misconduct by NBIB background investigators. DCIS will be able to investigate and pursue its own remedies at its discretion.

Our office continues to work three legacy NBIB-related cases accepted for Federal prosecution. In this semiannual reporting period, those cases had the following enforcement results:

Former Federal Background Investigator Indicted on 21 Federal Counts

On October 27, 2020, in the U.S. District Court for the District of Columbia, a former Federal background investigator was indicted on 11 counts of wire fraud and 10 counts of making false statements. This case is ongoing and further judicial action is expected.

Former Contract Background Investigator Sentenced and Ordered to Pay Full Restitution for Making False Statements

On February 9, 2021, a former contract background investigator was sentenced by the U.S. District Court for the District of Columbia to 3 years of probation and 3 months of home detention. Additionally, the court ordered the former contract background investigator to pay restitution of $254,555, a fine of $7,500, and a special assessment fee of $100.

This former contract background investigator had pled guilty in November 2020 to one count of making a false statement. The charge was based on our investigation after NBIB's Integrity Assurance group referred suspected fraud to our office. Our investigation found that the former contract background investigator falsified casework related to investigations used to determine the suitability of persons for positions impacting national security, involving access to classified information, or receiving or retaining security clearances. In total, the falsifications had cost OPM $254,555 in labor and travel costs.

Former Contract Background Investigator Who Falsified More Than 25 Reports of Investigation Pleads Guilty

On March 16, 2021, a former contract background investigator pled guilty in the U.S. District Court for the District of Columbia to one count of making a false statement. They had previously been charged by criminal information on March 9, 2021.

This case was predicated on a referral we received from NBIB's Integrity Assurance group that alleged the former contract background investigator had submitted false and inaccurate reports of investigation.

Our investigation found the former contract background investigator had submitted 26 falsified reports of investigation. These falsified reports and the associated recovery effort by NBIB cost OPM $105,186.

Further judicial action related to sentencing is anticipated.

Integrity Investigations Related to Fraud, Waste, or Abuse at OPM

As an essential part of the OPM OIG's oversight mission, our Office of Investigations investigates fraud, waste, abuse, or mismanagement by OPM employees. We are also required by the IG Act to report all substantiated allegations of misconduct by senior OPM officials.

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

Reports of Fraud, Waste, and Abuse from the OPM OIG Hotline

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

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

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

The majority of hotline contacts we receive regarding OPM programs and operations are customer service issues related to the OPM-administered retirement programs. Customer service issues received by the OPM OIG Hotline are referred to the relevant OPM program offices. This is an issue we have raised with OPM; we continue to work with the agency to ensure the OIG Hotline is focused on receiving reports of fraud, waste, and abuse.

We received 1,132 hotline contacts during the reporting period, and closed 1,233. A table located later in this report contains the summary of hotline activities received through telephone calls, emails, letters, or our website.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (Title 5 USC § 8902a), we suspend or debar health care providers whose actions demonstrate they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were 37,180 active suspensions and debarments of health care providers from participating in the FEHBP.

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

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

During the reporting period, our office issued 430 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 1,915 sanctions-related inquiries.

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

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

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

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

Pennsylvania Pharmacist Debarred for Lipitor Prescription Conspiracy

In March 2021, our office debarred a Pennsylvania pharmacist. The pharmacist and others knowingly transmitted and caused to be transmitted, by means of wire communication in interstate and foreign commerce, approximately $4.6 million false and fraudulent claims for reimbursement to a manufacturer.

From approximately March 2015 through October 2018, the pharmacist knowingly and willfully submitted approximately 196 false and

fraudulent Lipitor claims to Federal health care programs and was reimbursed approximately $1.7 million. The conspiracy involved the enrollment of pharmacy customers, with or without their knowledge and consent, in the Lipitor Savings Card program. Regardless of whether a customer's prescription called for brand-name Lipitor or permitted generic substitution, the pharmacist and others filled prescription bottles with cheaper, generic atorvastatin calcium and labeled those bottles as brand-name Lipitor. The pharmacist provided the falsely labeled bottles to patients and submitted the false and fraudulent claims for reimbursement to the manufacturer, based on the pharmacy's purported disbursement of the manufacturer's Lipitor.

In addition, the pharmacist ignored suspicious activity before filling oxycodone prescriptions for one individual. From approximately August 2017 through August 2018, the pharmacist knowingly and intentionally distributed and dispensed, outside the course of professional practice and not for a legitimate medical purpose, a mixture and substance containing a detectable amount of oxycodone, to the individual, with each distribution and dispensing constituting a separate count.

In July 2019, the pharmacist pled guilty to:

- One count of conspiracy to commit wire fraud by submitting false and fraudulent claims for Lipitor via interstate wires as part of a Lipitor Savings Card program; and
- 14 counts of knowingly and intentionally distributing and dispensing, outside the course of professional practice and not for a legitimate medical purpose, a mixture and substance containing a detectable amount of oxycodone, a Schedule II controlled substance.

In March 2020, the pharmacist was sentenced in the U.S. District Court for the Eastern District of Pennsylvania. The sentence included imprisonment for a period of 3 years, followed by a 2 year term of supervised release, and restitution of approximately $1.7 million.

The relevant statute, 5 U.S.C. § 8902a(b)(1), requires our office to debar health care providers who have been convicted of a criminal offense related to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply. Therefore, we are required to debar persons or entities convicted of this type of offense for a minimum period of three years. However, considering the mitigating and aggravating factors in this case, we determined that a five-year period of debarment is justified, in compliance with Title 5 Code of Federal Regulations (CFR) § 890.1008.

In addition, in March 2021, our office also debarred a pharmacy that was owned by the pharmacist. The pharmacy was debarred for a five-year period, concurrent with the pharmacist's debarment.

This case was referred to us by our Office of Investigations.

Pennsylvania Physician and Practice Debarred for Telemedicine Fraud Scheme

In March 2021, our office debarred a Pennsylvania physician involved in a telemedicine fraud scheme. The scheme involved writing prescriptions for medically unnecessary medical equipment to unsuspecting health care program beneficiaries, billing for services not needed or not provided as billed, and kickback conspiracies.

The physician was indicted and charged in the U.S. District Court for the Eastern District of Pennsylvania with conspiracy to commit health care fraud. In May 2019, he pled guilty as charged.

The conspiracy ran from approximately September 2016 through November 2018. During this time, the physician and others conspired with telemedicine companies to prescribe medically unnecessary items to patients, which caused the submission of approximately $5 million in false and fraudulent claims to Federal health care programs. The physician did not conduct in-person examinations, nor did he conduct meaningful telephonic evaluations prior to prescribing at least one, and often multiple, orthotic braces.

The physician and co-conspirators knowingly and willfully devised and executed, and attempted to execute, a scheme to defraud a Federal health care benefit program to obtain money and property owned by and under the custody and control of a health care benefit program in connection with the delivery of, and payment for, health care benefits, items, and services.

The debarment of the physician is for a five-year period, based on aggravating factors. In addition, in March 2021, our office debarred the physician's medical practice for a period concurrent with the physician's debarment.

This case was identified by the Administrative Sanctions Program Group.

Five Individuals and Four Physician-Owned Entities Suspended after Indictment Involving Kickback Scheme To Defraud Federal Health Care Programs

In January 2021, our office suspended a California medical spa owner, a physician, a health insurance company Special Investigations Unit investigator, and two spa administrative staff based on their May 2019 indictments for health care fraud which were filed with the U.S. District Court for the Central District of California.

The indictments were based on a kickback scheme to defraud Federal health care programs. Over a five-year period, patients were induced to visit California medical spas to receive free or discounted cosmetic procedures which were not covered by health insurance. In exchange for receiving the non-covered services, health insurance information was obtained from the patients and used by the spa owner, physician, and administrative staff to fraudulently bill insurance companies for medical services that were never provided.

The spa owner, physician and administrative staff successfully recruited other physicians to work part time at the spas and participate in their scheme. They opened bank accounts in the physicians' names, and their addresses on file with the insurance companies were changed to the addresses of the spas or post office boxes near the spas, giving the spas' owner access to the checks from the health insurance companies. The recruited physicians were paid a percentage of the funds that were fraudulently obtained from the health insurance claims.

The FEHBP health insurance carrier's Special Investigations Unit investigator involved in the scheme provided confidential information about

the carrier to the spa owner and others, which was used to submit false and fraudulent claims for reimbursement. In addition, the investigator worked to prevent the insurance companies from detecting the fraud by helping the spa owner to avoid responding to inquiries from fraud investigators, diverting attention of other Special Investigations Unit investigators away from the spas, and closing carrier investigations into fraud that was being committed at the spas. The Special Investigations Unit investigator also interfered with a Federal criminal investigation into the spa by aiding the owner and another individual in taking steps to prevent the discovery and successful prosecution of fraud at the spas. The Special Investigations Unit investigator received cash remunerations for the actions he took on behalf of the spas.

It is estimated that the conspiracy resulted in approximately $8 million in claim payments made by health insurance companies. Of this amount, approximately $202,000 was paid to the spa as a result of claims submitted to the FEHBP.

In accordance with 5 CFR §§ 890.1031(b)(1) and 890.1032, OPM may suspend a provider based on their indictment or conviction for a criminal offense that is a basis for mandatory debarment. Our office suspended the medical spa owner, physician, Special Investigations Unit investigator, and two spa administrative staff for an indefinite period, pending the outcomes of the individuals' trials. If the final outcome of the proceedings for the above indicted parties are convictions, mandatory debarments are warranted, in accordance with 5 U.S.C. § 8902a(b)(1).

In addition to these suspensions, in accordance with 5 U.S.C. § 8902a(c)(2), we debarred four physician owned entities, including, two spas, a home health care agency and an ambulatory health care facility. The entity debarments will also be for an indefinite period pending the outcome of the physician's trial.

This case was referred to us by our Office of Investigations.

Debarred Two Marketers and Five Entities as Result of Laboratory Kickback Scheme

In March 2021, our office debarred two marketers involved in a health care kickback scheme for a period of five years. The scheme involved fraudulent toxicology and DNA cancer screening tests that were not legitimately prescribed, not needed, not provided as billed, and which were the product of kickbacks. These claims submitted for the tests were products of a conspiracy between the marketers, beneficiaries, physicians, and owners of various companies including laboratory, finance, and insurance services.

From May 2014 through July 2017, the marketers conspired with beneficiaries, physicians, and owners to submit and cause the submission of false and fraudulent claims to a Federal health care program. During this period, approximately $36 million in false and fraudulent claims were submitted, of which the Federal health care program paid approximately $4.8 million. These false and fraudulent claims were not submitted to or paid by the FEHBP.

As part of this conspiracy, the marketers, along with other individuals, enticed low income beneficiaries with Wal-Mart gift cards to provide saliva and urine samples. The gift card inducements were intentionally disguised as a food assistance program for low income beneficiaries.

The saliva and urine samples were sent to a laboratory for unnecessary testing in exchange for commissions and/or kickbacks.

The parties collected samples from approximately 200 beneficiaries per day. Physicians were paid a flat fee per month to sign orders for the toxicology and DNA tests; however, they never saw the patients or established doctor–patient relationships with the patients, and the beneficiaries never received the test results.

The physicians provided signature stamps for use on the testing orders before sending the forms to the labs. The submitted urine samples were for any person regardless of whether the testing was necessary or whether the person had a history of drug or alcohol abuse. In addition, false diagnosis codes were used on the health care program claims to give the appearance of the need for the testing and ensure that the health care program would accept and pay the claims.

In August 2017, the marketers were arrested and pled guilty in the U.S. District Court for the Northern District of Texas. They were each charged with one count of 18 U.S.C. § 371 (18 U.S.C. § 1347), Conspiracy to Commit Health Care Fraud.

Our office debarred the two marketers for a five-year period, based on aggravating factors. In addition, in March 2021, we debarred the five entities owned and/or controlled by the two marketers for a five-year period, concurrent with the marketers' debarments.

This case was referred to us by our Office of Investigations.

EVALUATION ACTIVITIES

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

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

LEGAL AND LEGISLATIVE ACTIVITIES

Under the Inspector General Act of 1978, as amended, 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 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.

During this reporting period, the OIG continued to keep Congress fully and currently informed of OIG activities and issues affecting OPM programs and operations through briefings, meetings, and responses to Congressional inquiries.

STATISTICAL SUMMARY OF ENFORCEMENT ACTIVITIES

Investigative Actions and Recoveries:

Indictments and Criminal Informations	25
Arrests	23
Convictions	19
Criminal Complaints/Pre-Trial Diversion	3
Subjects Presented for Prosecution	53
Federal Venue	51
Criminal	28
Civil	23
State Venue	2
Local Venue	0
Expected Recovery Amount to OPM Programs	$21,272,280
Civil Judgments and Settlements	$14,207,978
Criminal Fines, Penalties, Assessments, and Forfeitures	$2,809,174
Administrative Recoveries	$4,255,128
Expected Recovery Amount for All Programs and Victims[3]	$391,387,060

Investigative Administrative Actions:

FY 2021 Investigative Reports Issued[4]	341
Issued between October 1, 2020 – March 31, 2021	341
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for FEHBP Suspension and Debarment	1

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

[4] The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports. As part of our transition to a new case management system, we revised our standards for the types of complaints that require Office of Investigations staff to generate an investigative report.

Personnel Suspensions, Terminations, or Resignations 0

Referral to the OIG's Office of Audits 0

Referral to an OPM Program Office 77

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued 430

FEHBP Provider Debarment and Suspension Inquiries 1,915

FEHBP Debarments and Suspensions in Effect at the End of Reporting Period 37,180

Table of Enforcement Activities[5]

	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened[6]	**1,087**	**120**	**0**	**10**	**1,217**
Investigations[7]	32	10	0	2	44
Preliminary Investigations[8]	104	47	0	4	155
FEHBP Carrier Notifications/Program Office	788	8	0	0	796
Complaints – All Other Sources/Proactive[9]	163	55	0	4	222
Cases Closed	1,148	82	21	6	**1,257**
Investigations	41	8	1	2	52
Preliminary Investigations	194	42	20	3	259
FEHBP Carrier Notifications/Program Office	789	2	0	0	791
Complaints – All Other Sources/Proactive	124	30	0	1	155
Cases In-Progress[10]	269	85	3	8	**365**
Investigations	126	35	3	3	167
Preliminary Investigations	71	28	0	5	104
FEHBP Carrier Notifications/Program Office	54	1	0	0	55
Complaints – All Other Sources/Proactive	18	21	0	0	39

[5] During this semiannual reporting period, the OPM OIG migrated investigative data to a new case management system. As part of the migration, how we categorize our various levels of investigative activity was changed. These new categories contain migrated data identified under the previous categorization scheme.

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

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

[8] 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.

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

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

OIG HOTLINE CASE ACTIVITIES

OIG HOTLINE CASES RECEIVED 1,132

Sources of OIG Hotline Cases Received

Website 720

Telephone 207

Letter 57

Email 148

In-Person 0

By OPM Program Office

Healthcare and Insurance 211

Customer Service 75

Healthcare Fraud, Waste, and Abuse Complaint 111

Other Healthcare and Insurance Issues 25

Retirement Services 233

Customer Service 146

Retirement Services Program Fraud, Waste, and Abuse 45

Other Retirement Services Issues 42

Other OPM Program Offices/Internal Matters 96

Customer Service 12

Other OPM Program/Internal Issues 81

Employee or Contractor Misconduct 3

External Agency Issues (not OPM-related) 592

OIG HOTLINE CASES REVIEWED AND CLOSED[11] 1,233

Outcome of OIG Hotline Cases Closed

Referred to External Agencies 30

Referred to OPM Program Office 330

Retirement Services 191

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

Healthcare and Insurance. 115

Other OPM Programs/Internal Matters. 24

No Further Action 870

Converted to a Case 3

OIG HOTLINE CASES PENDING[12] 202

By OPM Program Office

Healthcare and Insurance. 34

Retirement Services 106

Other OPM Program Offices/Internal Matters 20

External Agency Issues (not OPM-related) 42

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

APPENDICES

APPENDIX I-A

FINAL REPORTS ISSUED WITH QUESTIONED COSTS FOR INSURANCE PROGRAMS

October 1, 2020–March 31, 2021

	Subject	Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	4	$6,929,788
B.	Reports issued during the reporting period with findings	6	$7,695,289
	Subtotals (A+B)	10	$14,625,077
C.	Reports for which a management decision was made during the reporting period:	5	$11,575,507
	1. Net disallowed costs	N/A	$10,461,519
	a. Disallowed costs during the reporting period	N/A	$11,725,182[1]
	b. Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$1,263,663[2]
	2. Net allowed costs	N/A	$1,113,988
	a. Allowed costs during the reporting period	N/A	-$149,675[3]
	b. Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$1,263,663
D.	Reports for which no management decision has been made by the end of the reporting period	5	$3,049,570
E.	Reports for which no management decision has been made within 6 months of issuance	2	$1,621,920

[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

October 1, 2020–March 31, 2021

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

APPENDIX II

RESOLUTION OF QUESTIONED COSTS IN FINAL REPORTS FOR INSURANCE PROGRAMS

October 1, 2020–March 31, 2021

	Subject	Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$8,199,023
B.	Value of new audit recommendations issued during the reporting period	$7,695,289
	Subtotals (A+B)	$15,894,312
C.	Amounts recovered during the reporting period	$11,730,754
D.	Amounts allowed during the reporting period	$1,113,988
E.	Other adjustments	$0
	Subtotals (C+D+E)	$12,844,742
F.	Value of open recommendations at the end of the reporting period	$3,049,570

APPENDIX III

FINAL REPORTS ISSUED WITH RECOMMENDATIONS FOR BETTER USE OF FUNDS

October 1, 2020–March 31, 2021

	Subject	Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	1	$108,880,417
B.	Reports issued during the reporting period with findings	0	$0
	Subtotals (A+B)	1	$108,880,417
C.	Reports for which a management decision was made during the reporting period	0	$0
D.	Reports for which no management decision has been made by the end of the reporting period	1	$108,880,417
E.	Reports for which no management decision has been made within 6 months of issuance	1	$108,880,417

APPENDIX IV

INSURANCE AUDIT REPORTS ISSUED

October 1, 2020–March 31, 2021

Report Number	Subject	Date Issued	Questioned Costs
1D-2G-00-20-003	CareFirst BlueChoice, Inc. in Owings Mills, Maryland	November 30, 2020	$2,302,023
1C-UR-00-19-040	Humana Health Plan of Texas in Louisville, Kentucky	December 14, 2020	$0
1A-10-13-20-006	Highmark Blue Cross Blue Shield in Camp Hill and Pittsburgh, Pennsylvania	December 14, 2020	$101,264
1C-GA-00-20-031	MVP Health Care in Schenectady, New York	January 3, 2021	$0
1A-10-07-20-028	BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana	February 12, 2021	$135,194
1A-99-00-19-002	Duplicate Claim Payments at All Blue Cross Blue Shield Plans in Washington, D.C.	February 12, 2021	$2,095,900
1A-10-32-20-027	BlueCross BlueShield of Michigan in Detroit, Michigan	February 12, 2021	$2,648,338
1N-0A-00-20-023	Flexible Spending Account for Federal Employees as Administered by Wageworks, Inc. from September 1, 2016, through December 31, 2018 in Louisville, Kentucky	February 21, 2021	$0
1A-99-00-20-018	Enrollment at All Blue Cross and Blue Shield Plans for Contract Years 2018-2019 in Washington, D.C.	March 12, 2021	$412,570
1B-47-00-20-036	Claims Testing Audit of the Claim Processing Environment at American Postal Workers Union Health Plan in Glen Burnie, Maryland	March 26, 2021	$0
TOTAL			**$7,695,289**

APPENDIX V

INTERNAL AUDIT REPORTS ISSUED

October 1, 2020–March 31, 2021

Report Number	Subject	Date Issued
4A-HI-00-19-007	U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, D.C.	October 30, 2020
4A-RS-00-19-038	U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, D.C.	October 30, 2020
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
4A-IS-00-18-042	National Background Investigations Bureau's Backlog of Background Investigation Cases and the Effectiveness of the Quality Assurance Process in Washington, D.C.; Fort Meade, Maryland; and Boyers, Pennsylvania.	January 21, 2021

APPENDIX VI

INFORMATION SYSTEMS AUDIT REPORTS ISSUED

October 1, 2020–March 31, 2021

Report Number	Subject	Date Issued
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
4A-CI-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020
1C-52-00-20-011	Information Systems General and Application Controls at Health Alliance Plan of Michigan in Troy, Michigan	November 30, 2020
1C-A8-00-20-019	Information Systems General Controls at Baylor Scott and White Health Plan in Dallas, Texas	December 14, 2020
1A-10-85-20-021	Information Systems General and Application Controls at Carefirst BlueCross BlueShield in Owings Mills, Maryland	December 28, 2020
1C-2G-00-20-022	Information Systems General and Application Controls at Carefirst BlueChoice in Owings Mills, Maryland	December 28, 2020
1A-10-36-20-032	Information Systems General and Application Controls at Capital BlueCross in Harrisburg, Pennsylvania	February 21 2021
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021
1C-QA-00-20-040	Information Systems General Controls at Independent Health Association in Buffalo, New York	March 28, 2021

APPENDIX VII

DATA BRIEFS ISSUED

October 1, 2020–March 31, 2021

Report Number	Subject	Date Issued
1K-99-00-20-046	Downward Trends in FEHBP Members' Use of Preventive Care Services Due to COVID-19 Pandemic in Washington, D.C.	January 6, 2021

APPENDIX VIII

SUMMARY OF REPORTS MORE THAN SIX MONTHS OLD PENDING CORRECTIVE ACTION

As Of March 31, 2021

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

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

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[13]	Total
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1		1
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	3		4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	14		29
4K-RS-00-14-076	The Review of the U.S. Office of Personnel Management's Compliance with the Freedom of Information Act in Washington, D.C.	March 23, 2015	2		33
4A-RI-00-15-019	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015	2		7
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	15		27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	4		5
4A-CF-00-16-026	The U.S. Office of Personnel Management's Fiscal Year 2015 Improper Payments Reporting in Washington, D.C.	May 11, 2016	1		6
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, D.C.	July 8, 2016	4		6
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	4		4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	20		26
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	14		19
1C-JP-00-16-032	Information Systems General and Application Controls at United Healthcare in Plymouth, Minnesota	January 24, 2017	1	1	2
4A-CF-00-17-012	The U.S. Office of Personnel Management's Fiscal Year 2016 Improper Payments Reporting in Washington, D.C.	May 11, 2017	1		10
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	3		4
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York	June 30, 2017	2	2	15
4A-CF-00-17-044	Information Technology Security Controls of the U.S. Office of Personnel Management's Federal Financial System in Washington, D.C.	September 29, 2017	1		9

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[13]	Total
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	7		8
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	34		39
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	15		18
1C-ML-00-17-027	Information Systems General and Application Controls at AvMed Health Plan in Miami, Florida	December 18, 2017	3	3	16
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	19		21
4A-CI-00-18-022	Management Advisory Report - the U.S. Office of Personnel Management's Fiscal Year 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018	2		4
4K-RS-00-17-039	The U.S. Office of Personnel Management's Retirement Services' Imaging Operations in Washington, D.C.	March 14, 2018	1		3
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5		5
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1		2
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018	2		4
1C-PG-00-17-045	Information Systems General and Application Controls at Optima Health Plan in Virginia Beach, Virginia	May 10, 2018	2	2	20
4A-CI-00-18-044	Management Advisory Report - U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, D.C.	June 20, 2018	2		2
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	42		52
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, D.C.	November 15, 2018	20		23
1C-LB-00-18-007	Information Systems General and Application Controls at Health Net of California in Rancho Cordova, California	December 10, 2018	1	1	7
4K-CI-00-18-009	The U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, D.C.	December 21, 2018	1		3

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[13]	Total
1C-UX-00-18-019	Information Systems General and Application Controls at Medical Mutual of Ohio in Cleveland, Ohio	January 24, 2019	3	3	12
1C-8W-00-18-036	Information Systems General Controls at University of Pittsburgh Medical Center Health Plan in Pittsburgh, Pennsylvania	March 1, 2019	1	1	5
1C-LE-00-18-034	Information Systems General and Application Controls at Priority Health Plan in Grand Rapids, Michigan	March 5, 2019	2	2	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		5
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, D.C.	June 3, 2019	3		4
4A-HR-00-19-034	Independent Certified Public Accountants on the U.S. Office of Personnel Management Human Resources Solutions' Schedule of Assets and Liabilities in Washington, D.C.	June 6, 2019	3		4
4A-IS-00-19-035	Independent Certified Public Accountants on the U.S. Office of Personnel Management National Background Investigations Bureau's Details of Analysis and Assumptions Schedule in Washington, D.C.	June 6, 2019	5		5
4A-CI-00-19-006	Information Technology Security Controls of the U.S. Office of Personnel Management's Enterprise Human Resource Integration Data Warehouse in Washington, D.C.	June 17, 2019	4		13
4K-ES-00-18-041	Evaluation of the U.S. Office of Personnel Management's Employee Services' Senior Executive Service and Performance Management Office in Washington, D.C.	July 1, 2019	4		6
1C-59-00-19-005	Information Systems General and Application Controls at Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions in Downey and Corona, California	July 23, 2019	2	2	2
1G-LT-00-18-040	BENEFEDS as Administered by Long Term Care Partners, LLC for Contract Years 2014 through 2016 in Portsmouth, New Hampshire	September 11, 2019	3	3	5
4A-CF-00-19-026	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	October 3, 2019	7		7
1A-10-40-19-010	Information Systems General and Application Controls at Blue Cross Blue Shield of Mississippi in Flowood, Mississippi	October 21, 2019	1	1	11
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, D.C.	October 23, 2019	13		23

Report Number	Subject	Date Issued	Recommendations		
			Open	Resolved[13]	Total
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	44		47
4A-CF-00-19-025	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act of 2014 in Washington, D.C.	November 6, 2019	2		2
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, D.C.	November 18, 2019	20		20
4K-ES-00-19-032	Evaluation of the Presidential Rank Awards Program in Washington, D.C.	January 17, 2020	4		4
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	March 31, 2020	2		2
4A-RS-00-18-035	U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	12		12
1A-10-85-17-049	Claims Processing and Payment Operations at CareFirst Blue Cross Blue Shield in Owings Mills, Maryland	April 15, 2020	2	2	10
4A-CF-00-20-014	U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020	3		3
1C-ML-00-19-019	Audit of the Federal Employees Health Benefits Program Operations at AvMed in Gainesville, Florida	May 18, 2020	1	1	8
4A-CI-00-20-007	Information Technology Security Controls of the U.S. Office of Personnel Management's Electronic Official Personnel Folder System Report in Washington, D.C.	June 30, 2020	2		3
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	5		8
4A-DO-00-20-041	Management Advisory Report - Delegation of Authority to Operate and Maintain the Theodore Roosevelt Federal Building and the Federal Executive Institute in Washington, D.C.	August 5, 2020	3		4
1A-10-49-19-036	Horizon BlueCross BlueShield of New Jersey in Newark, New Jersey	September 8, 2020	1	1	33
1B-32-00-20-004	Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia	September 9, 2020	9	4	19
4A-CI-00-20-009	U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020	11		11

APPENDIX IX

MOST RECENT PEER REVIEW RESULTS

As Of March 31, 2021

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

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

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

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

[3] Due to the COVID-19 pandemic, the latest Peer Review of the Office of Investigations was postponed and has been tentatively rescheduled for October 2021.

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

APPENDIX X

INVESTIGATIVE RECOVERIES

October 1, 2020–March 31, 2021

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			$20,002,854	$4,275,600
	Healthcare & Insurance		$19,117,162	$3,496,183
		Administrative Debt Recoveries	$1,276,551	$1,245,824
		Carrier Settlements	$7,266,337	$1,827,387
		Voluntary Repayment Agreement	$10,574,274	$422,971
	Retirement Services		$885,691	$779,418
		Administrative Debt Recoveries	$457,632	$351,359
		Referred to Program Office	$428,059	$428,059
Civil			$281,219,182	$14,207,979
	Healthcare & Insurance		$281,219,182	$14,207,979
		Court Assessments/Fees	$3,700	$0
		Criminal Fines	$10,000	$0
		Criminal Judgments/Restitution	$88,651,242	$2,176,371
Criminal			$90,185,497	$2,809,174
	Healthcare & Insurance		$88,651,242	$2,176,371
		Court Assessments/Fees	$3,700	$0
		Criminal Fines	$10,000	$0
		Criminal Judgments/Restitution	$88,651,242	$2,176,371
	National Background Investigations		$254,556	$0
		Court Assessments/Fees	$100	$0
		Criminal Fines	$7,500	$0
		Criminal Judgments/Restitution	$254,556	$0
	Retirement Services		$1,279,699	$632,803
		Court Assessments/Fees	$300	$0
		Criminal Fines	$7,000	$0
		Criminal Judgments/Restitution	$1,279,699	$632,803
Grand Total			**$391,407,533**	**$21,292,753**

INDEX OF REPORTING REQUIREMENTS

(Inspector General Act of 1978, As Amended)

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OFFICE OF THE INSPECTOR GENERAL
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