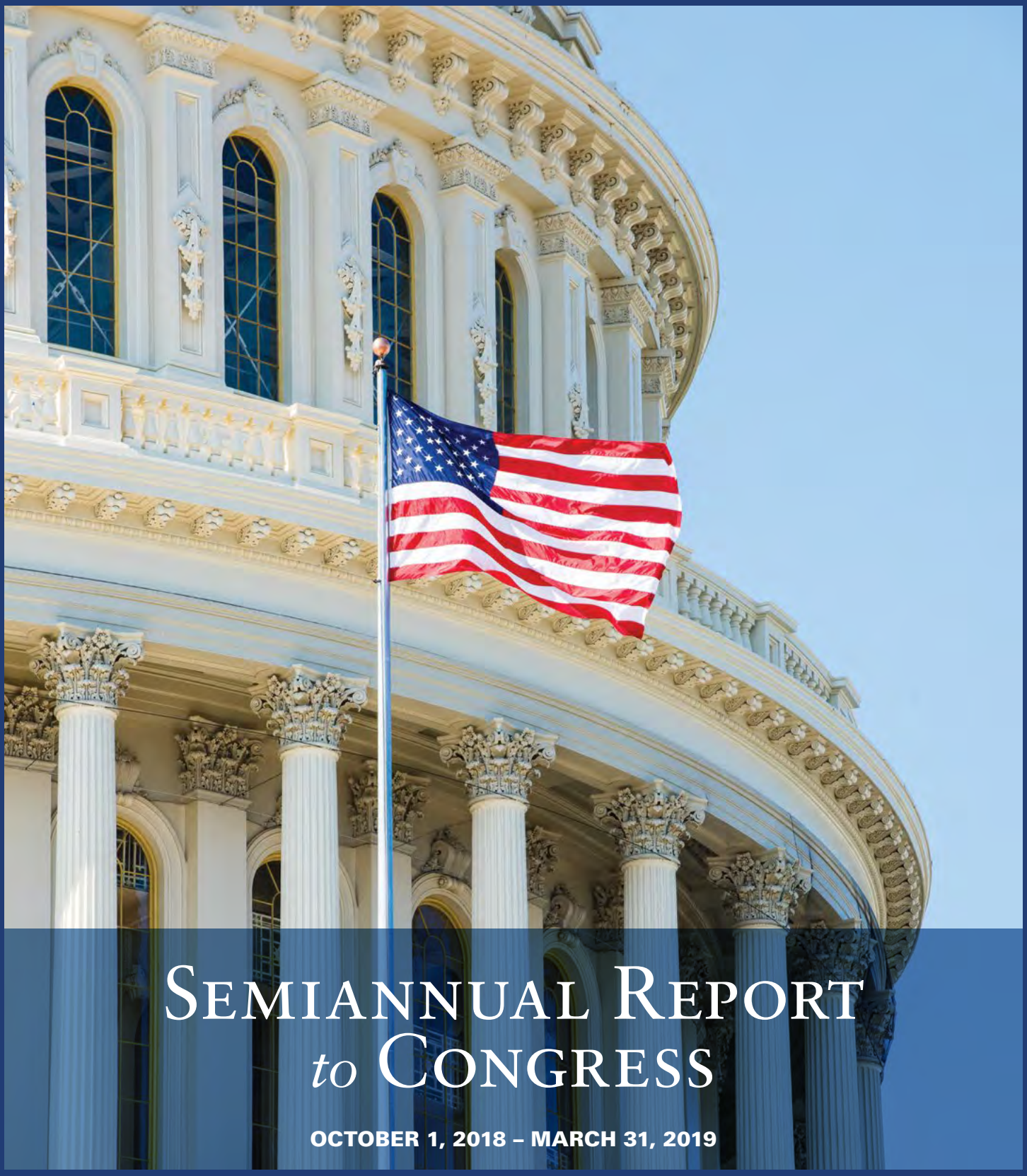


Semiannual Report *to* Congress

OCTOBER 1, 2018 – MARCH 31, 2019

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL

Productivity Indicators

FINANCIAL IMPACT:

Audit Recommendations for Recovery of Funds $3,075,997

Management Commitments to Recover Funds $12,592,209

Recoveries Through Investigative Actions $19,156,091

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

ACCOMPLISHMENTS:

Audit Reports Issued 20

Evaluation Reports Issued. 1

Management Advisories Issued 0

Investigations and Complaints Closed. 217

Indictments and Informations 74

Arrests 52

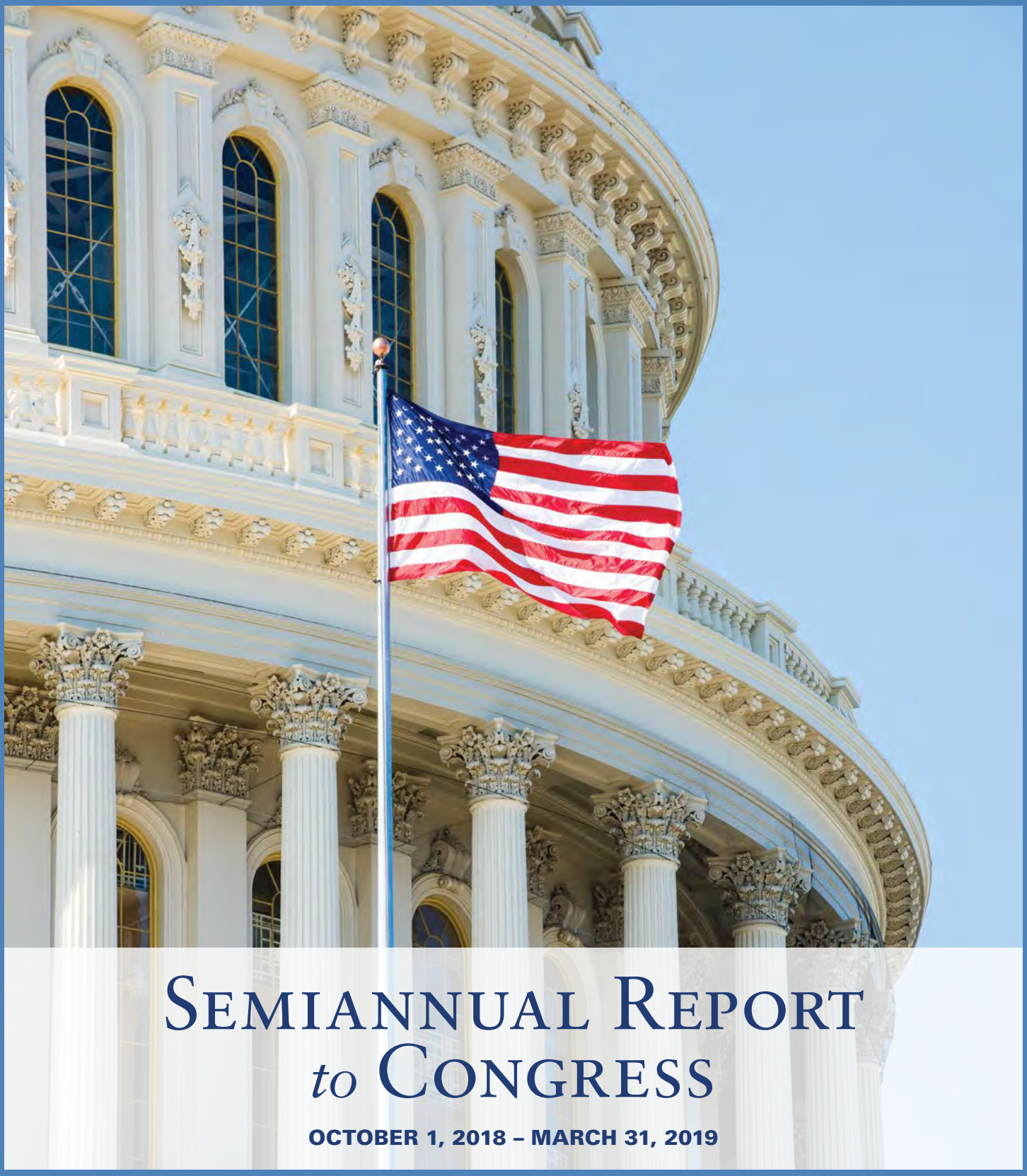
Convictions. 27

Hotline Contacts and Complaints Received 1,874

Hotline Contacts and Complaints Closed 1,489

FEHBP Provider Debarments and Suspensions 386

FEHBP Provider Debarment and Suspension Inquiries 2,147



Semiannual Report *to* Congress

OCTOBER 1, 2018 – MARCH 31, 2019

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL

Message from the Acting Inspector General

Like many Federal agencies, the U.S. Office of Personnel Management (OPM) has undergone a considerable number of transitions aimed at making the agency more efficient, effective, and accountable. Given that the Administration has proposed plans for a reorganization of OPM functions, I thought this might be a good opportunity to look back at how our civil service has grown and changed over the years.

Our modern civil service began with the passage of the Civil Service Act in 1883, which provided for a Civil Service Commission (CSC) of three members, not more than two of whom could be of the same political party. The authors of this first attempt to institute merit principles intended not only to eliminate the upheavals of the old spoils system, but also to encourage the best-qualified people to work for the Federal Government and provide all citizens with an equal chance to compete for public sector jobs. The CSC focused on the propriety of the hiring and removal procedures – it prepared application forms, established registers of individuals eligible for Federal employment, and organized local boards of examiners throughout the country. In 1920, its duties were expanded when the first civil service retirement law was enacted.

In the years following World War II, the primary challenge for the CSC was to see "whether a system conceived for an essentially negative purpose (i.e., the control of patronage and corruption in appointment to public office) could be adapted to modern needs, discoveries, and requirements in personnel management."[1] The CSC's mission continued to expand. The 1950s saw the creation of the Federal Employees' Group Life Insurance Program and the Federal Employees Health Benefits Program. In the 1960s, the CSC was tasked with additional duties such as managing relations with Government unions and eliminating discrimination in the civil service. Training programs for Federal employees also expanded significantly, including the establishment of the Federal Executive Institute, which today is still OPM's premier leadership training program.

These new responsibilities, however, created problems. Critics of the CSC pointed to the inherent conflict between the CSC's role as personnel management advisor to agencies and departments and its adjudicative role in hearing employees' appeals of violations of rules and procedures. In response to these criticisms, President James E. Carter, Jr., created the Federal Personnel Management Project to develop a comprehensive plan for civil service reform. The Project produced nine "option papers" defining various problems in the civil service system and

[1] OPM, *Biography of an Ideal: A History of the Civil Service*, at page 77.

(continued on next page)

outlining several possible solutions. These option papers were refined and compiled into a single report that the Administration presented to Congress, along with proposals for legislation and a reorganization plan.

Congress subsequently enacted the Civil Service Reform Act of 1978, which "endeavored to resolve both the procedural and organizational problems behind much of the criticism of the civil service" by dividing the CSC's responsibilities among several new entities, including OPM, the Merit Systems Protection Board, the Office of Special Counsel, and the Federal Labor Relations Authority.[2] This division of responsibilities allowed OPM to focus on serving as the President's chief advisor on civilian personnel matters.

Today, the possibility of reorganization is again on the horizon. The President's Budget for Fiscal Year 2020 includes a proposal to reorganize the civil service. The Budget proposes moving certain policy and workforce strategy functions to the Executive Office of the President; transferring 100 percent of the background investigation function to the U.S. Department of Defense (DOD); and merging the remaining OPM functions under a new, third "service" at the U.S. General Services Administration (GSA).

I would like to reassure Congress and the American taxpayers that our office is monitoring this effort closely. We have reached out to our counterparts at DOD and GSA Offices of the Inspector General, as well as the U.S. Government Accountability Office, to ensure that all aspects of these activities are receiving proper oversight.

I strongly encourage the Administration and Congress to work together to ensure that any plan developed will be an efficient use of taxpayer dollars and will allow the Federal civil service to thrive.

Norbert E. Vint
Acting Inspector General

[2] *Id.* at page 152

Mission Statement

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

VISION

Oversight Through Innovation.

CORE VALUES

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

Table of Contents

Field Offices

Audit Activities

Health Insurance Carrier Audits

OPM contracts with both private sector health plans and health plans operated or sponsored by Federal employee organizations to provide health insurance through the Federal Employees Health Benefits Program (FEHBP), as well as through the marketplaces under the Multi-State Plan Program created by the Patient Protection and Affordable Care Act (Affordable Care Act). 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 OIG's insurance audit universe encompasses over 200 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites fluctuates due to the addition, non-renewal, and merger of participating health insurance carriers. Combined premium payments for the health insurance program total over $50 billion annually. The health insurance plans that our office audits are classified as either community-rated or experience-rated carriers.

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

Experience-rated carriers are mostly fee-for-service plans (the largest being the Blue Cross Blue Shield (BCBS) health plans), but also include experience-rated HMOs. These carriers are reimbursed for actual claims paid and administrative expenses incurred, and paid a service charge that is determined in negotiation with OPM.

During the current reporting period, we issued 11 final audit reports on health plans participating in the FEHBP, which contained recommendations for the return of over $3 million to the OPM-administered trust fund.

COMMUNITY-RATED CARRIERS

The community-rated carrier audit universe includes 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 law and regulation.

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. This is to ensure that the Government receives the most favorable rates for a customer of similar size.

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

- the health plans selected appropriate SSSGs;
- the FEHBP rates are equivalent to those charged to the SSSGs; and
- the loadings applicable to the FEHBP rates are appropriate and reasonable.

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

Medical Loss Ratio Audits

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

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

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

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

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

Presbyterian Health Plan
Albuquerque, New Mexico
Report No. 1C-P2-00-18-014
March 7, 2019

Insufficient internal controls over the FEHBP MLR process were identified for multiple health plans.

Presbyterian Health Plan has participated in the FEHBP since 1991, and provides health benefits to FEHBP members in New Mexico. Our audit covered contract years 2014 and 2015. During this period, the FEHBP paid Presbyterian Health approximately $123.8 million in premiums.

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. This resulted in an MLR penalty underpayment due to OPM of $530,688 for 2015, and an additional $30,017 of lost investment income on the unpaid penalty calculated through December 31, 2018, for a total of $560,705 due to OPM. Although Presbyterian Health met the MLR threshold in 2014, our audit also identified errors in the MLR calculation for that year as well. Specifically, our audit identified the following:

- Presbyterian Health included medical and pharmacy claims not allowed by the FEHBP in the incurred claims total.
- Presbyterian Health incorrectly reported claims adjustments and health care receivables.
- Presbyterian Health could not support that it allocated Quality Health Improvement expenses accurately and appropriately in compliance with applicable Federal regulations.
- Presbyterian Health incorrectly reported and unreasonably allocated its tax expense.
- Presbyterian Health does not have sufficient internal controls over the FEHBP MLR process.

Group Health Cooperative
Seattle, Washington
Report No. 1C-54-00-18-015
February 6, 2019

Group Health Cooperative (GHC) has participated in the FEHBP since 1960, and provides health benefits to FEHBP members in most of Washington State and northern Idaho. The audit covered contract years 2013 through 2016. During this period, the FEHBP paid GHC approximately $1.1 billion in premiums.

The Certificates of Accurate MLR signed by GHC in all audited years were defective, resulting in MLR credit reductions of $1,345,290 for 2014; $1,086,940 for 2015; and an understated MLR credit of $14,727,560 for 2016. Finally, although GHC met the MLR threshold in 2013, there were also errors in that year's MLR calculation.

Specifically, our audit identified the following:

- GHC included medical and pharmacy claims not allowed by the FEHBP in the incurred claims total for all years (2013 through 2016).
- GHC inadvertently omitted pharmacy rebates for all years (2013–2016).
- GHC incorrectly reported health care receivables in 2013.
- GHC overstated its 2013 MLR premium by not removing a third party's dental premium.
- GHC overstated its 2016 Medicare subsidy received.
- GHC incorrectly reported tax expenses in 2013 and 2014.
- GHC did not have sufficient internal controls over the FEHBP MLR process.

Our audit did not disclose any findings related to GHC's procedures for quality health improvement expenses.

UnitedHealthcare of California
Cypress, California
Report No. 1C-CY-00-17-047
October 9, 2018

UnitedHealthcare of California has participated in the FEHBP since 2004, and provides health benefits to FEHBP members in the southern and central California areas. The audit covered contract years 2013 through 2015. During this period, the FEHBP paid UnitedHealthcare approximately $529.5 million in premiums.

The Certificates of Accurate MLR signed by UnitedHealthcare from 2013 through 2015 were defective, resulting in an overstated OPM MLR credit of $993,650 in contract year 2013, as well as understated OPM MLR credits of $4,895,933 and $2,301,758 for contract years 2014 and 2015, respectively. Specifically, our audit identified the following:

- UnitedHealthcare included claims for unsupported disabled dependents in its claims data for all audited years.
- UnitedHealthcare included medical claims for non-covered services in its 2013 incurred claims total.
- UnitedHealthcare did not maintain supporting documentation for the capitation benefit adjustment factors for contract years 2013 through 2015.

Our audit did not disclose any findings related to UnitedHealthcare's procedures for premium income; quality health improvements; taxes; fraud, waste, and abuse; debarment; audited financial statements; off-shore contracting; and its hold harmless language. Additionally, our audit did not disclose any findings related to our coordination of benefits and member eligibility claim reviews.

EXPERIENCE-RATED CARRIERS

The FEHBP offers a variety of experience-rated plans, including a service benefit plan and health plans operated or sponsored by Federal employee organizations, associations, or unions. 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.

Blue Cross Blue Shield Service Benefit Plan Audits

The BCBS Association, on behalf of 64 participating plans offered by 38 BCBS companies, has entered into a Governmentwide Service Benefit Plan contract with OPM to provide a fee-for-service 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 BCBS plans.

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, DC, 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 CareFirst BlueCross BlueShield, located in Washington, DC. These activities include acting as fiscal intermediary between the BCBS Association and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments for FEHBP claims, maintaining a history file of all FEHBP claims, and keeping an accounting for all FEP funds.

Below are two summaries of recent BCBS audits that are representative of our work.

Independence BlueCross
Philadelphia, Pennsylvania
Report No. 1A-10-55-18-010
January 17, 2019

Our audit of the FEHBP operations at Independence BlueCross (Independence BC) covered health benefit payments and credits as well as administrative expense charges. We also reviewed its cash management and fraud and abuse program activities and practices.

We questioned $451,584 in health benefit charges, administrative expenses, cash management activities, and lost investment income. The BCBS Association and Independence BC agreed with all of the questioned amounts.

Specifically, our audit identified the following:

- We questioned $212,570 in claim overpayments where Independence BC had not recovered and/or returned funds to the FEHBP.
- We questioned $238,409 in administrative expenses and applicable lost investment income, consisting of $224,556 for non-chargeable cost center and natural account expenses, and $13,853 for lost investment income on these questioned expenses.
- We determined that Independence BC had not returned $605 to the FEHBP when closing out the dedicated FEP investment account.

We verified that Independence BC subsequently returned all questioned amounts to the FEHBP.

BlueCross BlueShield of Western New York
Buffalo, New York
Report No. 1A-10-12-18-016
March 1, 2019

Our audit of the FEHBP operations at BCBS of Western New York (BCBS-WNY) covered health benefit payments and credits as well as administrative expense charges. We also reviewed its cash management and fraud and abuse program activities and practices.

BCBS of Western New York returned $896,931 to the FEHBP based on auditors' findings.

We questioned $896,931 in health benefit refunds and recoveries, administrative expense charges, cash management activities, and lost investment income. The BCBS Association and BCBS-WNY agreed with all of the questioned amounts. As part of our review, we verified that BCBS-WNY subsequently returned these questioned amounts to the FEHBP.

Our audit results are summarized as follows:

- We questioned $83,160 for health benefit refund and special plan invoice amounts that had not been returned to the FEHBP and $3,644 for lost investment income on FEP funds returned to the FEHBP in an untimely fashion. The questioned special plan invoice amounts included fraud and abuse recoveries and medical drug rebates.
- We questioned $803,720 in administrative expense charges and applicable lost

investment income consisting of: $287,158 for unallowable and/or unallocable cost center expenses; $164,308 for non-chargeable administrative expenses; $162,959 for quality improvement cost overcharges; $113,287 for Affordable Care Act cost overcharges; $29,061 for unreasonable cost center allocations; and $46,947 for applicable lost investment income on these questioned charges.

- We questioned $6,144 in excess funds that BCBS-WNY withdrew from the FEHBP letter of credit account and $263 for applicable lost investment income.

Global Audits

Global audits of BCBS plans are cross-cutting reviews of specific issues we determine are likely to cause improper payments. These audits cover all 64 BCBS plans offered by the 38 participating BCBS companies.

We did not issue any global audit reports during the reporting period.

Employee Organization Plans

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

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

We did not issue any audit reports 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 on page 1 of this report, the key difference between the categories stems from how premium rates are calculated.

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

Multi-State Plan Program

The Multi-State Plan (MSP) Program was established by Section 1334 of the Affordable Care Act. This provision directs OPM to contract with private health insurers (called issuers) to offer MSP products in each state and the District of Columbia. OPM negotiates contracts with MSP Program issuers, including rates and benefits, in consultation with States and marketplaces. In addition, OPM monitors the performance of MSP Program issuers and oversees compliance with legal requirements and contractual terms. OPM's Program Development and Support office, formerly the National Healthcare Operations office, has overall responsibility for program administration.

In 2017, the MSP Program universe consisted of approximately 23 State-level issuers covering 22 States. In 2018 and 2019, however, there was only one issuer that participated in the program (Arkansas BCBS). Our audits of the MSP Program assess the issuer's compliance with the provisions of its contract with OPM, and applicable Federal laws and regulations.

We did not issue any final reports for MSP audits during this reporting period.

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems support background investigations for Federal employees, the processing of retirement claims, and multiple Governmentwide human resources services. Private health insurance carriers participating in the FEHBP rely upon information systems to administer health benefits to millions of current and former Federal employees and their dependents. The ever-increasing frequency and sophistication of cyberattacks on both the private and public sector make 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 correct 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 over 50 OPM-owned major information systems as well as approximately 80 IT processing centers used by health carriers that contract with OPM to participate in the FEHBP. We issued seven IT system audit reports during the reporting period. Selected notable reports are summarized below.

Federal Information Security Modernization Act (FISMA) Audit for Fiscal Year 2018

Washington, D.C.
Report Number 4A-CI-00-18-038
October 30, 2018

The Fiscal Year (FY) 2018 FISMA Inspector General reporting metrics use a maturity model evaluation system derived from the National Institute of Standards and Technology's Cybersecurity Framework. The Cybersecurity Framework is comprised of 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 2018, OPM's cybersecurity maturity level is measured as "2 - Defined."

In addition, OPM's information security governance program has been a longstanding concern of the OIG. We have assessed it to be a material weakness or a significant deficiency in OPM's internal control structure since FY 2007. This year, we again consider deficiencies in the agency's information security governance program to be a material weakness in the agency's IT security internal control structure. The primary factors causing these issues are a lack of resources dedicated to IT operations and the agency's culture of minimizing the role of the Chief Information Officer.

OPM's IT security governance program has been assessed as a material weakness in the agency's IT internal control structure.

Like OPM's IT security governance program, we have reported either a material weakness or a significant deficiency in OPM's security assessment and authorization process since FY 2014 because of incomplete, inconsistent, and subpar work products. This year, we believe that the current control weaknesses are less severe than a material weakness but are still a significant deficiency in IT security controls. While there appears to be a valid security assessment and authorization in place for almost every major IT system in the agency's system inventory, the quality of the work and supporting documentation is questionable.

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

Risk Management – OPM is working to implement a comprehensive inventory management process for its system interconnections, hardware assets, and software. OPM is also working to establish a risk executive function that will help ensure that risk assessments are completed and risk is communicated throughout the agency.

Configuration Management – OPM continues to develop and maintain baseline configurations and approved standard configuration settings for its information systems. The organization 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 improve upon its program by establishing an agency ICAM strategy and ensuring that an auditing process is implemented for all contractor access.

Data Protection and Privacy – OPM has not implemented several of the FISMA requirements related to data protection and privacy. This is a new domain area for the FY 2018 FISMA metrics and maturity models that we will continue to monitor going forward.

Security Training – OPM has implemented an IT security training program, but the agency should perform a workforce assessment to identify any gaps in its IT security training needs.

Information Security Continuous Monitoring (ISCM) – OPM has established many of the policies and procedures surrounding ISCM, but the agency has not completed the implementation and enforcement of the policies. OPM also continues to struggle with conducting a security controls assessment on all of its information systems. This has been an ongoing weakness at OPM for over a decade.

Incident Response – OPM has made its greatest strides this FY in the incident response domain. Based upon our audit work, OPM has successfully implemented all of the FISMA metrics at the level of "consistently implemented" or higher. As such, we are closing our FY 2016 recommendation related to the incident response program.

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

OIG'S VULNERABILITY SCANNING

The vulnerability and compliance scanning exercise performed by OIG IT auditors during the course of an audit involves conducting automated scans on a sample of servers in a health insurance carrier's network environment using industry standard scanning tools. The goal of our scanning exercise is to identify systemic weaknesses in the carrier's configuration management, patch management, and/or vulnerability scanning programs. In order to maintain independence, the scans are conducted from an OIG laptop. We have developed thorough procedures to reduce the risk that the scans will have a negative effect on the carrier's operations and have established controls related to the confidentiality of the scan data we collect. Both the carrier and OIG agree to a "rules of engagement" document before any scanning takes place.

We have discovered that some carriers are reluctant to permit our scanning exercise because of concerns regarding external

computers connecting to their network, and potential harm to their IT environment. Our scanning process is designed so that there is minimal impact on carrier systems, and the risk of harm is extremely low. In all cases, we have successfully negotiated a process that meets our audit requirements while mitigating carriers' concerns.

Information Systems General and Application Controls at HealthNet of California

Rancho Cordova, California
Report Number 1C-LB-00-18-007
December 10, 2018

In February 2018, we issued a flash audit alert informing OPM that HealthNet of California and its parent company, Centene, refused to cooperate with our IT auditors and allow them to conduct vulnerability and compliance scans. HealthNet's actions were in direct violation of the company's contract with OPM and also disregarded the statutory authority of the OIG. OPM stepped in, however, and the contracting officer instructed HealthNet to allow OIG IT auditors to complete their work. HealthNet eventually agreed to let the audit proceed.

Our audit of the IT security controls of HealthNet and Centene determined that:

- Centene has implemented an adequate risk assessment methodology.
- Physical access controls could be improved.
- Centene could improve its network security posture by implementing certain additional controls.
- Centene does not have formally documented security configuration standards.
- Centene maintains adequate disaster recovery and business continuity plans to minimize interruptions to HealthNet operations.

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM operations and their corresponding internal controls. Our auditors are also responsible for conducting or overseeing certain statutorily required audits, such as the annual audit of OPM's consolidated financial statements required under the Chief Financial Officers Act of 1990. We also conduct performance audits covering other internal OPM programs and functions. 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 program, the time elapsed since the last audit, and our previous audit results.

We did not complete any internal performance audits during the reporting period.

OPM'S CONSOLIDATED FINANCIAL STATEMENT AUDITS

The Chief Financial Officers Act of 1990 requires that audits of OPM's financial statements be conducted 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, 2018, and for the fiscal year then-ended. The contract requires that the audit be performed in accordance with Generally Accepted Government Auditing Standards (GAGAS) and Office of Management and Budget (OMB) Bulletin No. 19-01, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements include the agency's Retirement Program, FEHBP, Federal Employees Group Life Insurance (FEGLI), 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, background investigations, and employee training. The Salaries and Expenses Funds provide the resources used by OPM for the administrative costs of the agency.

Grant Thornton is responsible for, among other tasks, issuing an audit report that includes:

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

The OIG oversees Grant Thornton's performance of the audit to ensure that it is conducted in accordance with the terms of the contract and is in compliance with GAGAS and other authoritative references. Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings, reviewing Grant Thornton's work papers, and coordinating the issuance of audit reports. Our review disclosed no instances where Grant Thornton did not comply in all material respects with GAGAS.

In addition to the consolidated financial statements, Grant Thornton performed the audit of the Closing Package Financial Statements as of September 30, 2018. The contract requires that the audit be done in accordance with GAGAS and OMB Bulletin No. 19-01. The U.S. Department of the Treasury (Treasury) and the Government Accountability Office use the Closing Package in preparing and auditing the *Financial Report of the United States Government*.

OPM's FY 2018 Consolidated Financial Statements Washington, D.C.
Report No. 4A-CF-00-18-024
November 14, 2018

Information Systems Control Environment Material Weakness Reported in FY 2018.

Grant Thornton audited OPM's financial statements, which comprise the consolidated balance sheets as of September 30, 2017 and 2018, the related consolidated statements of net cost, changes in net position, and the combined statements of budgetary resources for the years then-ended, and the related notes to the consolidated financial statements (collectively, the financial statements). Grant Thornton also audited the individual balance sheets of the Retirement, FEHBP, and FEGLI (collectively, the Programs), as of September 30, 2017 and 2018, and the Programs' related individual financial statements for those years.

Grant Thornton reported that OPM's consolidated financial statements and the Programs' individual financial statements as of and for the years ended September 30, 2017 and 2018, were presented fairly, in all material respects, and in conformity with U.S. Generally Accepted Accounting Principles. Grant Thornton's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

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

Agency management is responsible for establishing and maintaining internal controls to achieve specific internal control objectives related to operations, reporting, and compliance. This includes establishing information systems controls, as management relies extensively on information systems for the administration and processing of its programs, to both process and account for their expenditures, as well as for financial reporting.

During FY 2018, deficiencies noted in FY 2017 continued to exist, and Grant Thornton's testing identified similar control issues in both design and operation of key controls. The information system issues identified in FY 2018 included repetitive conditions consistent with prior years as well as new deficiencies. The noted deficiencies in OPM's information systems control environment in the areas of Security Management, Logical and Physical Access, Configuration Management, and Interface/Data Transmission Controls are considered in the aggregate to be a material weakness.

OPM concurred with the findings and recommendations reported by Grant Thornton.

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

OPM's FY 2018 Closing Package Financial Statements

Washington, D.C.
Report No. 4A-CF-00-18-025
November 14, 2018

OPM's FY 2018 Closing Package Statements Receive Another Clean Opinion.

The Closing Package Financial Statements are required to be audited in accordance with GAGAS and the provisions of OMB's Bulletin No. 19-01. OPM's Closing Package Financial Statement Report comprise the Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) Reconciliation Report – Reclassified Balance Sheet as of September 30, 2018; the related GTAS Reconciliation Reports – Reclassified Statement of Net Cost and Reclassified Statement of Operations and Changes in Net Position for the year then-ended; and the related notes to the financial statements. The notes to the financial statements include the following:

- the GTAS Closing Package Lines Loaded Report, and
- the Financial Report (FR) Notes Report (except for information in the FR Notes Report entitled "2017 – September," "Prior Year," "PY," "Previously Reported," "Line Item Changes," "Threshold," and the information as of and for the year ended September 30, 2017, in the "Text Data" of the FR Notes Reports).

Grant Thornton reported that OPM's closing package financial statements presented fairly, in all material respects, the financial position of the agency as of September 30, 2018, and its net costs and changes in net position for the year then-ended, in accordance with accounting principles generally accepted in the United States, as promulgated by the Federal Accounting Standards Advisory Board.

Grant Thornton noted no matters involving the internal control over the financial process for the Closing Package Financial Statements that are considered a material weakness or significant deficiency. In addition, Grant Thornton disclosed no instances of noncompliance or other matters required to be reported.

The objectives of Grant Thornton's audits of the Closing Package Financial Statements did not include expressing an opinion on internal controls or compliance with laws and regulations. Therefore, Grant Thornton did not express such opinions.

Special Audits

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

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

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

Triple-S Salud's FEHBP Pharmacy Operations as Administered by MC-21 Corporation for Contract Years 2012 Through 2015

San Juan, Puerto Rico
Report Number 1H-05-00-17-017
December 10, 2018

Weak controls led to payment of $679,616 in claims for ineligible dependents.

We completed a performance audit of the Triple-S Salud's pharmacy benefits operations as administered by MC-21 Corporation. Our audit included reviews of administrative fees, claims processing, drug manufacturer rebates, the fraud and abuse program, and performance guarantees as they relate to the FEHBP for contract years 2012 through 2015.

We determined Triple-S Salud needs to strengthen its procedures and controls related to dependent eligibility.

Specifically, our audit identified the following deficiency that requires corrective action:

- Triple-S Salud paid $679,616 in pharmacy claims for 197 dependents age 26 or older whose eligibility to participate in the FEHBP could not be supported.

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

Enforcement Activities

Investigative Activities

OPM-administered trust funds, from which benefits are paid under the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI, amount to over $1 trillion. These programs cover over 8 million current and retired Federal civilian employees and eligible family members, and disburse over $140 billion in benefits annually.

The Office of Investigations conducts criminal, civil, and administrative investigations of fraud, waste, abuse, and mismanagement related to OPM programs and operations. We actively coordinate with the U.S. Department of Justice (DOJ) and other Federal, State, and local law enforcement authorities. Our investigations often lead to criminal convictions, civil and criminal recoveries, and administrative actions, including debarments from participation in Federal programs, thereby protecting Federal employees, annuitants, and their families from future harm and victimization.

The Office of Investigations prioritizes protecting Federal employees and their dependents from patient harm, as well as protecting the financial and program integrity of OPM. Recent areas of focus include the ongoing fight against the opioid crisis and prescription drug abuse within the FEHBP, as well as working towards the President's Management Agenda goal of reducing improper payments by providing oversight of the FEHBP and the Retirement Programs. Additionally, we diligently work to protect national security as it relates to background investigations, and we identify and report program deficiencies to internal and external stakeholders to improve OPM program integrity.

We achieve our greatest efficiency with a data-driven approach to assessing OPM programs and operations. These analytical efforts allow us to maximize investigative resources and set priorities. In this reporting period, the Office of Investigations opened 405 cases and closed 217. Our investigative efforts led to 52 arrests, 74 indictments and informations, 27 convictions, and $19,156,091 in monetary recoveries to OPM-administered trust funds. Many of our investigations occur jointly with other Federal law enforcement agencies, and criminal, civil, and administrative recoveries and fines of $88,484,165 were returned to the General Fund of the Treasury. For a statistical summary of the Office of Investigation's investigative activities, refer to the tables on pages 33-34.

Below is an overview of our investigative priorities, observed trends in fraud, waste, and abuse, and summaries of representative cases for each priority. To the extent that pending criminal matters are discussed herein and, unless otherwise explicitly stated, the crimes and charges are alleged and all defendants and parties are presumed innocent unless proven guilty in a court of law.

INVESTIGATIVE PRIORITY: THE ONGOING NATIONAL OPIOID AND DRUG ABUSE CRISIS AND ITS FEHBP IMPACT

Data-Driven Case Development and Public/Private Teamwork

Aggressive monitoring and investigation by the OIG has led to the identification and prosecution of various frauds which prey on victims of the opioid epidemic.

The Nation continues to suffer from the sweeping opioid and drug abuse crisis. The Center for Disease Control and Prevention identified over 70,000 opioid-related overdose deaths in 2017, and the epidemic has been an underlying contributor to the life expectancy of the average American dropping for the third consecutive year. Thirty-five percent of opioid overdose deaths involve prescription opioids, killing an estimated 46 people per day.

Federal employees and their families are not spared from the reaches of the opioid epidemic, and the FEHBP has faced substantial negative impacts from the crisis. In his 2017 memorandum on "Combatting the National Drug and Opioid Crisis," the President declared the opioid crisis a public health emergency and directed a multi-agency response to combat the national demand for these drugs. Addressing this crisis remains a high priority for the Office of Investigations, and our oversight strategies continue to evolve as we seek to protect Federal employees, retirees, and their dependents.

The vulnerabilities and fraud, waste, and abuse encountered in the opioid crisis continue to evolve beyond pill mills and diversionary schemes and expand throughout the health care ecosystem. Unethical sober homes and substance abuse clinics re-victimize those seeking treatment, and aggressive pass-through billing schemes attempt to defraud the FEHBP by seeking inflated reimbursement, often for medically unnecessary services that do little to help patients and their families. The ancillary costs of treating opioid epidemic victims continue as a substantial cost to the FEHBP.

__Drug diversion__ is the practice of transferring legally prescribed medications from the individual for whom it was prescribed to another person for illicit use.

A __pill mill__ is a health care provider, facility, or pharmacy that prescribes and/or dispenses drugs without legitimate medical purpose.

A __sober home__ provides a safe and drug-free residence for individuals suffering from addiction. Unscrupulous homes often submit patients to unnecessary, expensive, and excessive testing.

__Pass-through billing schemes__ involve providers paying a laboratory to perform tests but filing the claim themselves or through another third party, sometimes in exchange for kickbacks. Recently, the Office of Investigations has observed and investigated schemes where the sample is processed at a laboratory and billed through a rural hospital or health center that receives a higher reimbursement rate from the FEHBP carrier, allowing the bad actor to retain the difference.

__Patient brokering__ involves referring patients to facilities for monetary gain rather than for therapeutic purposes. The referring party often receives a kickback for referring the patient to the particular facility.

The Office of Investigations continues to assess program impacts, track costs, analyze trends, and perform criminal investigations related to the opioid crisis' impact on the FEHBP. We use cooperative measures and increased data

utilization to amplify our investigative resources. In 2017, we joined a DOJ taskforce dedicated to prosecuting opioid-related health care fraud, and we recently joined the Health Care Fraud Prevention Partnership, a public-private fraud prevention group. Our most recent initiative encourages greater partnership with the OPM Healthcare and Insurance Contracting Office and the private insurance carriers who contract with OPM to provide health benefits in identifying the providers (doctors, pharmacists, and facilities) involved in opioid-related schemes.

Because OPM does not have a comprehensive, all-encompassing data warehouse for health care claims, the Office of Investigations leverages our partnerships with the carriers through referrals and other cooperative efforts. In March 2019, we met with Aetna representatives who provided an overview of its opioid strategy, and we requested the carrier provide data collected in the formulation of the plan's efforts to reduce opioid and drug abuse. The Office of Investigations has identified similar programs by other carriers that we may use to generate leads that can amount to criminal or civil prosecutions and administrative actions (suspension and debarment) that will protect and reduce patient harm to the FEHBP population and beyond. In addition, the data sharing from carriers allows us to strengthen our own data analytics program to generate more investigative opportunities in our nationwide efforts to fight the opioid crisis' effects within the FEHBP, as seen in the following cases we worked during this reporting period.

Pennsylvania Pill Mill Broken Up

An OIG investigation into a Pennsylvania pill mill led to the arrest and indictment of 14 people.

The OPM OIG, during a November 2016 multiagency meeting involving the Drug Enforcement Agency (DEA), Federal Bureau of Investigation (FBI), U.S. Department of Health and Human Services OIG (HHS OIG), and U.S. Department of Labor OIG, received a referral regarding a number of Pennsylvania providers. They were allegedly billing for services not rendered and medically unnecessary services in order to prescribe Schedule II narcotics, including opioids like oxycodone, and routinely ignoring the warning signs of addiction or drug diversion. Physicians at the provider also allegedly operated without a valid DEA license, billed for services not rendered, and issued controlled substances without medical need or beyond medical guidelines. Some patients allegedly paid cash for opioid prescriptions under the guise of "office visit" fees or exchanged sexual favors with the providers for these drugs.

In addition to the grave risk of patient harm, the FEHBP paid $134,229 in claims to the providers. One provider's medical license was suspended and a suspension notice was submitted to OPM's debarment official.

Fourteen people involved in this alleged pill mill operation have been indicted and arrested for crimes including maintaining drug-involved premises, conspiracy to distribute a controlled substance, and aiding and abetting. In January and February of 2019, several of the providers pled guilty. The others, if convicted, face substantial prison time and fines depending on their degree of involvement.

Anatomy of an Opioid Kickback Scheme

Patient brokering – referring an addicted patient to a treatment center for the referring party's personal financial gain – has become a hallmark of fraud related to the opioid epidemic.

Fraud schemes that target victims of the opioid crisis often begin with "patient brokering," a practice which involves the referral of an addicted patient into a rehabilitation facility or a sober home,

which earns the referring party an illegal kickback. The patient often receives medically unnecessary or sub-quality treatment, if they receive treatment at all.

In 2018, Congress passed the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the "SUPPORT Act") to further the fight against the opioid crisis. Included in the SUPPORT Act's provisions is the Eliminating Kickbacks in Recovery Act of 2018 (EKRA). The EKRA's all-payor anti-kickback provisions prohibit compensation for referrals to sober homes, clinical treatment facilities, or laboratories and will allow us to aggressively target criminal and dishonest sober homes that prey on drug users seeking treatment for addiction to opioids and other drugs. We intend to use this law and other Federal and State statutes to investigate those entities practicing patient brokering and accepting bribes.

Urinalysis is particularly vulnerable to fraud. During the course of a patient's stay in a sober home, unscrupulous owners may require the patient to submit urine samples multiple times a week. This practice is frivolous, costly, and medically unnecessary because of the length of time that trace markers for drugs remain in the body. These tests are typically conducted for the sole purpose of increasing payouts from insurance carriers. A single test for more than a dozen drugs may bill each drug as a discrete test to further increase improper reimbursement, in a practice known as "unbundling." Urinalysis samples are often sent to a lab (or multiple labs) owned by the sober home, or one where there is a kickback arrangement between the two.

The Office of Investigations uses data analytics and carrier referrals to identify urinalysis that is not medically necessary, exorbitantly billed, or otherwise fraudulent. We pursue these cases under various statutes and use FEHBP suspension and debarment actions when unscrupulous sober homes put their patients at a risk of harm.

Due to such schemes, the addicted patients in many of these sober homes ultimately never receive the treatment they need. Their addiction and rehabilitation struggles continue, possibly even as the target of other schemes, as do the higher ancillary medical costs for the additional treatments and interventions they receive for overdoses. Kickback schemes increase overall health system costs and premiums for the commercial population. The Council of Economic Advisers estimated the cost of the opioid crisis in 2015 at $504 billion, and fraud schemes that exploit the vulnerable seeking treatment continue to contribute to that figure. In the context of the FEHBP, these increased costs mean increased spending of both taxpayer and enrollee dollars.

The OIG is in the process of developing several ongoing cases that we hope to present in future semiannual reports as successfully protecting one of the most vulnerable FEHBP populations, as well as the financial integrity of the program itself, from these schemes.

Sober Home Pass-Through Billing Scheme Dissolved

Numerous individuals charged with crimes related to sober home pass-through scheme.

On January 19, 2019, the CEO of a Florida sober home pled guilty to conspiracy to commit health care fraud. The individual was part of a sober home and pass-through billing kickback scheme that billed for services not rendered, used unlicensed facilities and staff, and double billed for urinalysis testing. Ultimately, the fraud cost the FEHBP more than $589,000.

A separate subject, the owner and founder of this sober home, is also under indictment for his part in this scheme, whereby a separate

health care facility performed non-medically necessary services and billed for residents who in fact were no longer receiving services. The facility also partially billed for nonexistent therapy sessions, falsified sign-in sheets, and otherwise misrepresented that patients received treatment when they had not.

Additionally, both the sober home and the health care facility fraudulently used urine drug screens to increase profits by splitting samples to double reimbursement from different laboratories, duplicating testing, and double billing for tests. Urinalysis was sometimes conducted 2–4 times per week (far exceeding the rate necessary to detect drug use) and billed through a company owned by the CEO of the sober home.

The owner/founder and two patient brokers, in addition to the CEO, were charged with various crimes, including conspiracy to commit health care and wire fraud, and money laundering. The remaining coconspirators are set to go to trial in August 2019.

Rural Hospital Pass-Through Billing Schemes

Pass-through billing, particularly as it relates to the opioid epidemic and rural health care centers, is an emergent and concerning fraud and kickback scheme that the Office of Investigations is tracking.

Rural hospital pass-through billing schemes often begin with struggling hospitals in rural areas. These facilities provide incredibly important health care resources to underserved populations across the country but subsist on razor-thin operating margins. In recent years, bad actors have begun purchasing controlling stakes in these hospitals in order to implement a scheme that increases the rural hospital's profits at the expense of the wellbeing of patients and the financial integrity of programs like the FEHBP. Services, particularly drug-related tests, are billed through the rural hospital despite the services being rendered elsewhere.

More and more frequently, the Office of Investigations has found that the laboratories that do the testing will actually bill through the purchased rural hospital or health care center because these entities receive much higher reimbursement rates due to special provider arrangements. Some rural medical care centers have reported outrageous increases in patient volume and profits despite not substantially expanding services. Insurance carriers, and by extension the FEHBP, pay for multiple tests at these special rates, and the higher costs result in higher premiums and more expensive care. Overall, we have identified potential exposure of over $30 million related to pass-through and rural-hospital billing schemes. Our office is taking an aggressive investigative stance towards recognizing and combatting these schemes in efforts we look forward to presenting in future semiannual reports.

INVESTIGATIVE PRIORITY: IMPROPER PAYMENTS

The Office of Investigations pursues improper payments, particularly from the FEHBP and Retirement Programs. These improper payments are disbursements that should not have been made or were made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. The reduction of these improper payments is a President's Management Agenda goal across all Executive Branch agencies, and the Office of Investigations works to pursue criminal and civil cases against fraud, waste, and abuse that cause public money to be wasted. In FY 2018, OPM reported the FEHBP and Retirement Programs made over a combined $355.5 million in improper payments.

Improper Payments Involving the FEHBP

Below are some examples of FEHBP investigations involving improper payments.

$200 Million Mississippi Compounding Pharmacy Scheme Nets More Guilty Pleas

During the reporting period, additional individuals involved in a $200 million compounding pharmacy fraud scheme pled guilty to charges of health care fraud, conspiracy to commit health care fraud, and conspiracy to defraud the U.S. Government. These participants include the owners of the compounding pharmacies whose aggressively fraudulent billing practices and prescription schemes cost the Government millions of dollars. They also provided kickbacks to patients in order to prescribe medically unnecessary medications.

Between 2012 and 2016, a group of Mississippi compounding pharmacies operated a $200 million scheme that defrauded Federal Government programs, including the FEHBP, by fraudulently formulating, marketing, prescribing, and billing for compounded medications. The prescriptions for these medications were predicated on a system of kickbacks, bribes, and money laundering. The compounded medications prescribed were not medically necessary and often relied on preprinted prescription forms already filled out with the names of beneficiaries and only needing the signature of the prescribers allegedly taking part in the scheme. In some cases, there was no medical consultation or doctor–patient relationship.

The total amount of FEHBP claims paid to the alleged conspirators is approximately $2.69 million. The Government is currently pursuing forfeiture actions for restitution, though the portion to be returned to the FEHBP is yet to be determined. This case was a cooperative effort between many agencies, including our office, the FBI, the HHS OIG, and the Medicare Fraud Strike Force, among others.

Texas Providers Convicted, Cardiology Group To Repay $1.5 Million in Fraud Scheme

The FBI referred a citizen complaint alleging billing fraud to our office after the complainant had purchased weight loss treatment (vitamin B12 injections) from the coupon website Groupon. Our investigation found that a four-bed private clinic in Texas attempted unnecessary diagnostic tests and billed tens of thousands of dollars to BCBS. The co-owner of the hospital also owned a health care network that "sold" its claims for flat fees and billed out-of-network services to charge health insurance carriers a higher rate in a pass-through billing scheme. The co-owner kept the difference from these excess reimbursements.

The FEHBP had paid approximately $86,000 to various entities involved in this scheme. Three people, the co-owner and two medical doctors, were indicted in May 2017 on one count of conspiracy to commit health care fraud and three counts of money laundering. The co-owner later was also indicted on a separate instance of conspiracy to commit health care fraud for charges involving a cardiology practice.

On December 10, 2018, the cardiology practice pled guilty to conspiracy to commit health care fraud and accepted responsibility for $1.5 million in improper claims and will repay that amount over 5 years. The FEHBP has $51,100 in exposure related to this portion of the case that it intends to recoup via settlement.

On February 22, 2019, a jury convicted two of the subjects on all counts. Sentencing is set for June 2019, and one subject will face a second trial on June 21, 2019.

Pioneering Use of the Travel Act in Kickback, Health Care Bribery Scheme

OIG successfully uses the Travel Act to prosecute kickbacks as violations of Texas' commercial bribery law, despite the FEHBP's exclusion from the Federal Anti-Kickback Statute.

A trial charging multiple defendants with conspiracy to commit health care fraud and the Travel Act predicated upon violations of Texas' commercial bribery law lasted through the end of the reportable period. Ten other individuals have already pled guilty for crimes related to the $200 million kickback and health care conspiracy.

Work by the Office of Investigations revealed that from 2009 to 2012, the principals of a physician-owned surgical hospital paid bribes and kickbacks to surgeons in exchange for referring patients to the hospital. The bribes were often concealed as marketing funds paid through bogus "co-marketing agreements," and the surgeons spent most of the bribes marketing their personal medical practices or on personal expenses.

As a further inducement, and in an effort to entice patients with out-of-network benefits to receive services at their hospital, the hospital often did not collect or even attempt to collect coinsurance or patient-responsibility payments owed under out-of-network benefits. Instead, certain coconspirators routinely guaranteed to both patients and the kickback recipients that patients' total out-of-pocket expenses would be no more than an in-network facility, despite the fact that the hospital billed the patients' health insurance carriers at higher out-of-network rates. In many cases, the hospital waived patients' financial responsibility entirely, and the waived fees were written off as uncollected "bad debt" to conceal the patient discounts from insurance carriers. Ultimately, the FEHBP expended more than $18.15 million in improper payments during the 3-year scheme.

The indictments vary by defendant but include violations of the Travel Act, aiding and abetting commercial bribery, conspiracy to pay and receive health care bribes and kickbacks, and money laundering. Several defendants are eligible for prison sentences over 15 years, with one facing a possible 65 years of incarceration.

This investigation and prosecution via the Travel Act represents an aggressive and successful attempt to combat fraud despite the continued and problematic exclusion of the FEHBP from the Federal Anti-Kickback Statute. By investigating cases through certain State-level commercial bribery laws and as violations of the Travel Act, we are able to better investigate and prevent patient harm to FEHBP enrollees and pursue providers receiving improper payments. While many kickback and fraud schemes do not involve violations of the Travel Act, this case serves as a model for using alternative statutes to collaborate with States against kickback and fraud schemes that would create program harm.

Improper Payments Involving Retirement Services

Below are some examples of investigations conducted by our office to recover improper retirement payments.

Starved Annuitant's Caretaker Arrested for Stealing Annuity

Nursing assistant arrested for stealing annuity and exploiting an elderly OPM annuitant.

A Federal annuitant died at the U.S. Department of Veterans Affairs (VA) Medical Center in Fayetteville, North Carolina, several days after being admitted. The annuitant was suffering from

severe starvation (scaled 9 out of 10), raising suspicions of elder abuse.

The North Carolina State Bureau of Investigation contacted our office about possible health care fraud because a nursing assistant who worked as the home health care provider had obtained power of attorney for all of the annuitant's financial and medical matters, including their OPM-administered annuity. However, a VA psychologist determined that the annuitant had not been competent to transfer power of attorney. The actions taken by the home health care provider entrusted with the annuitant's well-being allegedly constituted civil and/or criminal fraud.

The nursing assistant received $25,867 in payments from OPM's FEGLI because of an altered beneficiary form, and $64,385 in misdirected OPM monthly retirement payments intended for the annuitant. The loss amount by theft totaled $133,265. An arrest warrant was issued on December 4, 2018, for obtaining property by false pretense and exploitation of a disabled/elderly person, both of which are felonies. The Hoke County Sheriff's Office arrested the nursing assistant the next day and she is awaiting trial.

Daughter Admits to Theft of $70,000 in OPM Improper Payments

In March 2019, the daughter of a deceased annuitant retiree pled guilty to theft of Government funds for stealing more than $70,000 in improper OPM retirement payments. The daughter's mother had died in June 2014, but the death went unreported to OPM until October 2016, when OPM's Retirement Inspections referred the case to us for investigation.

When interviewed by OIG special agents, the daughter readily confessed to impersonating her mother twice when contacting OPM about the annuity, and to forging her mother's name on correspondence after her death. The $71,701 had been converted to pay outstanding medical bills from the mother's protracted illness and for the daughter's personal use.

Daughter of Deceased Annuitant Arrested for Aggravated Identity Theft, Theft of $120,000

In January 2019, the daughter of a deceased annuitant who received $121,985 in improper payments from OPM's Retirement Services was indicted and arrested on eight counts of mail fraud, eight counts of theft of Government property, and one count of aggravated identity theft.

The improper payments occurred after the survivor annuitant died in December 2001 and lasted for nearly 15 years, until September 2016. The overpayments totaled $123,314, of which OPM recovered $1,329 through the reclamation process. Additionally, the investigation also discovered that the Defense Finance Accounting Service continued annuity payments and had correspondence in their records purportedly signed by the deceased after December 2001.

OIG special agents along with the Defense Criminal Investigative Service and local authorities conducted the arrest. Legal proceedings for this case remain ongoing.

INVESTIGATIVE PRIOIRTY: NATIONAL SECURITY

Continuing Oversight to Ensure the Fitness of Background Investigations

The Office of Investigations provides external oversight to the National Background Investigations Bureau (NBIB), which conducts background investigations of Federal job applicants, employees, members of the armed services, and contractor personnel for suitability and security purposes. Allowing

the employment of or granting security clearances to potentially unsuitable persons through fraudulent, falsified, incomplete, or incorrect background investigations creates vulnerabilities within the Federal workforce detrimental to Government operations. The integrity of these background investigations is crucial to ensuring that only trustworthy individuals have access to sensitive and classified information.

The Office of Investigations' special agents investigate allegations of falsification by NBIB background investigators. While a phased transfer of some NBIB functions to the U.S. Department of Defense is ongoing, the OPM OIG currently maintains oversight responsibility for current investigations and those yet-unreported cases that occur while NBIB is a bureau of OPM.

NBIB Contract Background Investigator Pleads Guilty After Falsifying Reports of Investigation

Investigations into work performed by one National Background Investigations Bureau contractor found 37 falsifications over an approximately 8 year period.

OPM has a robust integrity assurance program that utilizes a variety of methods to ensure the validity of background investigations. That program detected multiple inconsistencies in a contract background investigator's reports of investigation that warranted further scrutiny. A case sampling found 37 falsifications between October 2006 and March 2015, resulting in a background investigation recovery labor cost of over $189,000. When interviewed by OIG special agents, the former background investigator admitted that she falsified the reports of investigation. She pled guilty to making false statements and was sentenced to 36 months of probation, 100 hours of community service, and full restitution of the $189,000.

NBIB Employee to Plead Guilty for 48 Instances of Falsification

The OIG received a referral from NBIB's Integrity Assurance office regarding falsifications made by an NBIB background investigator. The falsifications were discovered during a quality review conducted by NBIB. The investigation found 48 instances of falsification. On October 31, 2018, the case was accepted for prosecution by the United States Attorney's Office for the District of Columbia, and on November 14, 2018, the OIG received notification that the background investigator intends to plead guilty to making a false statement. Additionally, the background investigator will participate in a video interview regarding their falsifications that will be used for NBIB training.

INVESTIGATIVE PRIORITY: INTEGRITY INVESTIGATIONS

Oversight of OPM Programs and Operations

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations into fraud, waste, abuse, and mismanagement at OPM. As per the Inspector General Act of 1978, as amended, cases involving senior positions within OPM must be reported to Congress in our semiannual reports. Additionally, we investigate cases involving OPM employees and contractors that are referred through the OIG Hotline. Integrity investigations may involve whistleblowers and/or retaliation, and so are an important part of the OIG's mission of providing independent oversight and reducing program vulnerabilities.

Three OCIO Prohibited Personnel Actions Referred

In November 2015, the OPM OIG received allegations involving prohibited personnel practices in the Office of the Chief Information Officer (OCIO) by two senior officials regarding the hiring and appointment of multiple employees.

The OIG's investigation found that one of the senior officials helped an employee by providing advanced knowledge of a position description in an unauthorized advantage. Additionally, the employee recommended editorial changes to the position description's content, duties, and knowledge required, and sent these recommendations to the senior official. The employee's deletions and changes allowed their résumé to better match the position for which they were eventually hired.

OIG investigators found that the same senior official gave a different employee an unauthorized advantage by using their résumé as the basis for a job announcement that led to the hiring of the employee in a term appointment detail. This employee was also appointed to a position within the OCIO that the employee was unqualified to hold.

A second senior official worked to have a position reclassified under a particular job series so that a third employee (separate from the two referenced above) could be hired despite not having the necessary qualifications for the posting's original job series.

All three actions were found to be prohibited personnel practices. The United States Attorney's Office declined prosecution on August 8, 2016, in lieu of administrative remedies available to OPM. The OIG referred the case to the Acting Director of OPM and the U.S. Office of Special Counsel (OSC) for further action.

Senior FEI Official Referred to OSC for Inappropriate Hiring Practices

The OIG substantiated allegations of improper personnel practices in the hiring and promotion of an FEI faculty member.

We investigated allegations of prohibited personnel practices by a senior official at OPM's Federal Executive Institute (FEI) regarding the hiring and promotion of a faculty member. The senior official encouraged the hiring of a friend and neighbor, as well as encouraged the promotion of that individual to full-time employment status in order to secure benefits from full-time Federal employment. We referred this case to the United States Attorney's Office for the District of Columbia, which declined the case on August 14, 2017, and January 24, 2018, in lieu of administrative remedies available to OPM. We referred the case to the Acting Director of OPM and OSC for appropriate action.

The senior official provided the new hire's résumé to another senior employee in the FEI, though did not specifically instruct that the person be hired. The investigative subject also revised the new hire's résumé despite claiming not to recall seeing the résumé when asked by OIG investigators, and met with their friend to discuss converting employment to full time. Communications between the subject senior official and another FEI official encouraged promoting the faculty member from an intermittent, time-limited employee (and thereby ineligible for benefits) to a full-time employee eligible for all benefits of Federal employment (e.g., health care benefits, retirement, etc.). The FEI official granted that request. The hired individual was the only FEI faculty member who had only a bachelor's degree and no collegiate or equivalent teaching experience in academia.

Our investigation concluded that the subject senior official engaged in prohibited personnel practices in the hiring and promotion of the new faculty member. Specifically, the friendship and status of neighbors create a reasonable conclusion that the subject senior official provided professional introductions, encouraged the hiring, and advocated for the promotion/conversion to full-time status based on that friendship.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority, 5 U.S.C. § 8902a, we suspend or debar health care providers whose actions demonstrate that they are not sufficiently responsible to participate in the FEHBP. At the end of this reporting period, there were 35,950 active debarments and suspensions of health care providers from the FEHBP.

During the reporting period, our office issued 386 administrative sanctions—including both debarments and suspensions—of health care providers who have committed violations that affect the FEHBP and its enrollees. In addition, we responded to 2,147 sanctions-related inquiries from other Government entities, FEHBP carriers, private companies, and health care providers.

> ***Debarment*** *disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. 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 is 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.*

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 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 FEHBP as well as Federal employees, annuitants, and their dependents 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.

New Mexico Physician and Clinic Debarred for Endangering Patient Safety

As a result of a referral from our Office of Investigations, in October 2018 we debarred a New Mexico oncologist who operated a cancer treatment center in Las Cruces, New Mexico. The New Mexico Medical Board, after receiving numerous complaints, found that the physician posed a clear and immediate danger to the public health and safety if he continued to practice medicine.

The Medical Board determined that the oncologist did not provide patient treatment in accordance with protocols within the standard of medical care in failing to adequately and appropriately diagnose, evaluate, monitor, and treat patients. Further, the Board found that he did not disclose to patients the seriousness of the side effects and adverse reactions to chemotherapy. Finally, multiple complaints indicated that he was rude and unprofessional

during his interactions with patients and family members.

The Medical Board concluded that the oncologist's conduct constituted unprofessional behavior, and that his actions were in violation of multiple laws and regulations including:

- gross negligence in the practice of a licensee;
- failure to furnish the Medical Board with information requested;
- conduct unbecoming of a person licensed to practice or detrimental to the best interests of the public;
- improper management of medical records, including failure to maintain timely, accurate, legible, and complete medical records;
- failure to provide pertinent and necessary medical records to a physician in a timely manner when legally requested to do so by the patient or by a legally designated representative of the patient; and
- interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient.

The New Mexico Medical Board suspended the physician's medical license indefinitely. In addition, the physician voluntarily surrendered his controlled substance registration to the State of New Mexico Board of Pharmacy.

Our debarment of the oncologist is for an indefinite period. The clinic owned and operated by the oncologist was also debarred. From August 1, 2015, to July 10, 2017, the physician submitted $781,324 in claims to the FEHBP, and was paid $267,043.

Michigan Physician Debarred for Health Care Fraud

One provider debarred by the OIG submitted nearly $10 million in claims for services not actually provided to patients.

In November 2018, we debarred a Michigan physician based on his conviction in the United States District Court for the Eastern District of Michigan for health care fraud and conspiracy to commit health care fraud. The physician specialized in family medicine.

According to the evidence presented at trial, from May 2008 until May 2014, the physician knowingly submitted nearly $10 million in fraudulent claims for nerve block injections and other services that he knew had not been provided to patients. In 2009, Medicare imposed a requirement that claims submitted by the physician undergo medical review prior to payment. To circumvent the review process, the physician created shell companies with family members and friends serving as straw owners to conceal his involvement, and continued to submit fraudulent claims to Medicare.

In November 2017, he was convicted and sentenced to 15 years in prison with 3 years of supervised release, and ordered to pay $9.2 million in restitution.

We imposed an 18-year term of debarment on the physician. In addition, based on ownership and control, we debarred the medical facility that was used in committing the fraudulent activities. Our Office of Investigations referred this case to our Administrative Sanctions Program.

South Carolina Chiropractor Obstructing a Health Care Fraud Investigation

In late 2018, the OIG debarred one chiropractor and two physicians for their roles in an extensive drug trafficking organization.

In December 2018, we debarred a chiropractor licensed in South Carolina after he pled guilty to obstruction of a criminal health care investigation. He admitted to deliberately obstructing justice in a health care fraud investigation by coercing his patients to falsely state that they received a chiropractic adjustment at each visit when in fact no chiropractic adjustment was provided. He falsified medical records and provided false information to federal investigators. From July 2005 through August 2013, he submitted $617,828 in claims to the FEHBP and was paid $267,419.

In January 2018, the District Court for the District of South Carolina sentenced the physician to two years of supervised release.

We imposed a 3-year term of debarment on the chiropractor and his clinic. This case was referred to us by the BCBS Association.

Michigan Chiropractor and Two Physicians Debarred for Distribution of Controlled Substances and Money Laundering

In December 2018, we debarred a Michigan chiropractor and two physicians that participated in a health care fraud conspiracy. The chiropractor and physicians were convicted in the United States District Court for the Eastern District of Michigan for conspiracy to distribute and possession with intent to distribute controlled substances. The chiropractor was also convicted of conspiracy to commit money laundering.

The chiropractor was the leader of a large-scale prescription drug trafficking organization operating in Michigan and Florida. The chiropractor and members of his organization secured written prescriptions from medical doctors for controlled substances, primarily Roxicodone and oxycodone, which were filled at various pharmacies. The prescriptions for these drugs were written outside the course of usual medical practice for no legitimate purpose. According to the indictment, the chiropractor's organization distributed approximately 1 million pills, and grossed approximately $5.7 million from illegal street sales.

As part of the plea agreement, the chiropractor admitted that from 2013 to 2015, he was the leader of the conspiracy and recruited pharmacists, physicians, and patient marketers to participate in his scheme. He pleaded guilty to conspiracy to distribute Schedule II controlled substances and money laundering.

In April 2018, he was sentenced to 15 years of incarceration with 3 years of supervised release; and received a forfeiture judgment of $1,844,000. We debarred the chiropractor for 18 years based upon his periods of incarceration and supervised release.

In addition, two of his co-conspirators, both physicians, pled guilty to conspiracy to distribute and possession with intent to distribute controlled substances. They received sentences ranging from 24 to 33 months in prison, with 2 years of supervised release. We debarred each physician for a period of five years.

Under the FEHBP's administrative sanctions statutory authority, convictions constitute a mandatory basis for debarment for a minimum of three years. However, we determined that

longer periods of debarment were warranted because the offenses were planned in advance, endangered the public's health and safety, and occurred repeatedly over a long period of time. 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 programs and operations to prevent fraud, waste, and abuse. Our evaluators can quickly analyze 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. Our evaluation reports provide OPM management with findings and recommendations that will assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

OPM's Preservation of Electronic Records

Washington, D.C.
Report No. 4K-CI-00-18-009
December 21, 2018

OPM's OCIO lacks adequate oversight of the Records Management Program.

We conducted this evaluation in response to a June 2017 request from members of the United States Senate Committee on Homeland Security and Governmental Affairs to review OPM's processes and compliance with applicable legal standards for preserving certain electronic records as Federal records.

The objective of our evaluation was to determine OPM's compliance with the Federal guidance related to the preservation of electronic records. During this evaluation, we found that OPM's OCIO lacks adequate oversight of the Records Management Program. Specifically we found:

- The lack of a permanent Records Officer to oversee the many facets of the Records Management Program has left OPM at risk with respect to managing and preserving electronic records.
- OPM has not updated its records schedules to be media neutral (electronic or hard copy).
- OPM has not issued any specific guidance on the use of Government-issued smartphones, to include restrictions on installing certain applications or procedures on the preservation of smartphone-generated records related to government business.

Statistical Summary of Enforcement Activities

INVESTIGATIVE ACTIONS AND RECOVERIES:

Indictments and Informations	74
Arrests	52
Convictions	27
Criminal Complaints/Pre-Trial Diversion	2
Subjects Presented for Prosecution	210
Federal Venue	208
Criminal	68
Civil	140
State Venue	1
Local Venue	1
Expected Recovery Amount to OPM Programs	$19,156,091
Civil Judgments and Settlements	$3,183,905
Criminal Fines, Penalties, Assessments, and Forfeitures	$867,234
Administrative Recoveries	$15,104,952
Expected Recovery Amount for All Programs and Victims[3]	$88,484,165

INVESTIGATIVE ADMINISTRATIVE ACTIONS:

FY 2019 Investigative Reports Issued[4]	233
Issued between October 1, 2018–March 31, 2019	233
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	2
Health Care Cases Referred to the OIG for Suspension and Debarment	2
NBIB Cases Referred to OPM for Suspension and Debarment	0
Personnel Suspensions and Terminations	3
Referral to the OIG's Office of Audits	1
Referral to OPM Program Office	26

ADMINISTRATIVE SANCTIONS ACTIVITY:

FEHBP Debarments and Suspensions Issued	386
FEHBP Provider Debarment and Suspension Inquiries	2,147
FEHBP Debarments and Suspensions in Effect at End of Reporting Period	35,950

[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. The total reports issued and the breakout between Semiannual Report periods has been included to amend the previous submission total and reflect totals using a consistent, more accurate methodology.

OIG Investigative Case Activities

	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Cases Opened	**312**	**68**	**23**	**2**	**405**
Investigations	46	7	3	1	57
Complaints	266	61	20	1	348
Inquiries Opened	**749**	**5**	**0**	**0**	**754**
Referrals - FEHBP Carriers/Program Office	631	4	0	0	635
Referrals - All Other Sources/Proactive	118	1	0	0	119
Cases Closed	**170**	**37**	**10**	**0**	**217**
Investigations	27	3	2	0	32
Complaints	143	34	8	0	185
Inquiries Closed[5]	**773**	**16**	**1**	**1**	**791**
Referrals - FEHBP Carriers/Program Office	651	8	1	0	660
Referrals - All Other Sources/Proactive	122	8	0	1	131
Cases In-Progress[6]	**570**	**97**	**36**	**2**	**705**
Investigations	176	44	15	2	237
Complaints	394	53	21	0	468
Inquiries In-Progress[7]	**355**	**1**	**0**	**1**	**357**
Referrals - FEHBP Carriers/Program Office	346	0	0	0	346
Referrals - All Other Sources/Proactive	9	1	0	1	11

[5] Cases closed may have opened in a previous reporting period.
[6] Cases in-progress may have been opened in a previous reporting period.
[7] Inquiries in-progress may have been opened in a previous reporting period.

OIG Hotline Case Activity

OIG Hotline Cases Received	**1,874**
Sources of OIG Hotline Cases Received	
Website	728
Telephone	950
Letter	77
Email	119
In-Person	0
By OPM Program Office	
Healthcare and Insurance	283
Customer Service	91
Billing Disputes	108
Other Healthcare and Insurance Issue	84
Retirement Services	450
Customer Service	354
Annuity Calculation	64
Other Retirement Services Issues	32
Other OPM Program Offices/Internal Matters	104
Customer Service	74
Other OPM Program/Internal Issues	10
Employee or Contractor Misconduct	20
External Agency Issue (not OPM-related)	1,037
OIG Hotline Cases Reviewed and Closed	**1,489**
Outcome of OIG Hotline Cases Closed	
Referred to External Agency	608
Referred to OPM Program Office	358
Retirement Services	246
Healthcare and Insurance	78
Other OPM Programs/Internal Matters	34
No Further Action	507
Converted to a Case	16
OIG Hotline Cases Pending[8]	**385**
By OPM Program Office	
Healthcare and Insurance	145
Retirement Services	94
Other OPM Program Offices/Internal Matters	30
External Agency Issue (not OPM-related)	116

[8] 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, 2018 to March 31, 2019

Subject	Number of Reports	Questioned Costs
A. Reports for which no management decision had been made by the beginning of the reporting period	3	$73,025,424
B. Reports issued during the reporting period with findings	6	$3,075,997
Subtotals (A+B)	9	$76,101,421
C. Reports for which a management decision was made during the reporting period:	4	$12,760,374
1. Disallowed costs	N/A	$12,592,209
2. Costs not disallowed	N/A	$168,165[1]
D. Reports for which no management decision has been made by the end of the reporting period	5	$63,341,047
E. Reports for which no management decision has been made within 6 months of issuance	2	$62,226,073

[1] Represents the net costs, which includes overpayments and underpayments, to insurance carriers. Underpayments are held (not returned to insurance carriers) until overpayments are recovered.

APPENDIX I – B

Final Reports Issued With Questioned Costs for All Other Audited Entities
October 1, 2018 to March 31, 2019

Subject	Number of Reports	Dollar Value
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. Disallowed costs	N/A	$0
2. Costs not disallowed	N/A	$0
D. Reports for which no management decision has been made by the end of the reporting period	0	$0
E. Reports for which no management decision has been made within 6 months of issuance	0	$0

APPENDIX II

Resolution of Questioned Costs in Final Reports for Insurance Programs

October 1, 2018 to March 31, 2019

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$111,325,252
B.	Value of new audit recommendations issued during the reporting period	$3,075,997
	Subtotals (A+B)	$114,401,249
C.	Amounts recovered during the reporting period	$5,691,968
D.	Amounts allowed during the reporting period	$1,266,951
E.	Other adjustments	($109,568)[1]
	Subtotals (C+D+E)	$6,849,351
F.	Value of open recommendations at the end of the reporting period	$107,551,898

[1] Represents additional lost investment income.

APPENDIX III

Final Reports Issued With Recommendations for Better Use of Funds

October 1, 2018 to March 31, 2019

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, 2018 to March 31, 2019

Report Number	Subject	Date Issued	Questioned Costs
1C-CY-00-17-047	UnitedHealthcare of California in Cypress, California	October 9, 2018	$0
1H-02-00-18-018	Government Employees Health Association, Inc.'s Drug Manufacturer Rebates as Administered by Express Scripts, Inc. for Contract Years 2013 and 2014 in Franklin Lakes, New Jersey	October 18, 2018	$0
1C-75-00-17-040	Humana Health Plan, Inc. – Chicago in Louisville, Kentucky	November 1, 2018	$0
1H-05-00-17-017	Triple-S Salud's Federal Employees Health Benefits Program Pharmacy Operations as Administered by MC-21 Corporation for Contract Years 2012 through 2015 in San Juan, Puerto Rico	December 10, 2018	$679,616
lA-10-55-18-010	Independence Blue Cross in Philadelphia, Pennsylvania	January 17, 2019	$451,584
1A-10-78-18-028	Blue Cross Blue Shield of Minnesota, Eagan, Minnesota	January 24, 2019	$0
1A-10-41-18-008	Florida Blue in Jacksonville, Florida	January 29, 2019	$443,669
1C-54-00-18-015	Group Health Cooperative in Seattle, Washington	February 6, 2019	$0
1A-10-12-18-016	Blue Cross Blue Shield of Western New York in Buffalo, New York	March 1, 2019	$896,931
1C-P2-00-18-014	Presbyterian Health Plan in Albuquerque, New Mexico	March 7, 2019	$560,705
1H-01-00-18-020	Blue Cross Blue Shield Association's Federal Employee Program Service Benefit Plan's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Health for Contract Years 2014 through 2016 in Scottsdale, Arizona	March 26, 2019	$43,492
TOTAL			**$3,075,997**

APPENDIX V

Internal Audit Reports Issued
October 1, 2018 to March 31, 2019

Report Number	Subject	Date Issued
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, DC	November 15, 2018
4A-CF-00-18-025	The U.S. Office of Personnel Management's Fiscal Year 2018 Closing Package Financial Statements in Washington, DC	November 15, 2018

APPENDIX VI

Information Systems Audit Reports Issued
October 1, 2018 to March 31, 2019

Report Number	Subject	Date Issued
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, DC	October 30, 2018
1C-MH-00-18-003	Information Systems General and Application Controls at Humana Health Plan, Inc. in Louisville, Kentucky	November 19, 2018
1C-LB-00-18-007	Information Systems General and Application Controls at Health Net of California in Rancho Cordova, California	December 10, 2018
1C-UX-00-18-019	Information Systems General and Application Controls at Medical Mutual of Ohio in Cleveland, Ohio	January 24, 2019
1B-31-00-18-033	Information Systems General and Application Controls at Government Employee Health Association, in Kansas City, Missouri	March 1, 2019
1C-8W-00-18-036	Information Systems General and Application Controls at University of Pittsburgh Medical Center Health Plan in Pittsburgh, Pennsylvania	March 1, 2019
1C-LE-00-18-034	Information Systems General and Application Controls at Priority Health Plan in Grand Rapids, Michigan	March 5, 2019

APPENDIX VII

Evaluation Reports Issued
October 1, 2018 to March 31, 2019

Report Number	Subject	Date Issued
4K-CI-00-18-009	Evaluation of the U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, DC	December 21, 2018

APPENDIX VIII

Summary of Reports More Than Six Months Old Pending Corrective Action
As of March 31, 2019

			Recommendations	
Report Number	Subject	Date Issued	Open	Total
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, DC	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, DC	November 14, 2008	1	6
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, DC	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, DC	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, DC	November 10, 2010	3	7
4A-CI-00-10-019	Federal Information Security Management Act for Fiscal Year 2010 in Washington, DC	November 10, 2010	2	41
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, DC	September 14, 2011	3	14

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CI-00-11-009	Federal Information Security Management Act for Fiscal Year 2011 in Washington, D.C.	November 9, 2011	3	29
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, DC	November 14, 2011	1	7
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, DC	November 5, 2012	4	18
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, DC	November 15, 2012	1	3
1K-RS-00-12-031	The U.S. Office of Personnel Management's Voice over Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, DC	December 12, 2012	1	2
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, DC	November 21, 2013	5	16
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, DC	December 13, 2013	1	1
4A-CI-00-14-015	Information Technology Security Controls of the U.S. Office of Personnel Management's Development Test Production General Support System Fiscal Year 2014 in Washington, DC	June 6, 2014	2	6
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, DC	November 10, 2014	3	4

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, DC	November 12, 2014	15	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, DC	March 23, 2015	2	3
4A-RS-00-13-033	Assessing the Internal Controls over the U.S. Office of Personnel Management's Retirement Services' Retirement Eligibility and Services Office in Washington, DC	April 13, 2015	1	7
4A-CI-00-15-055	Flash Audit Alert – the U.S. Office of Personnel Management's Infrastructure Improvement in Washington, DC	June 17, 2015	1	2
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, DC	July 29, 2015	4	7
4A-RI-00-16-014	Management Alert of Serious Concerns Related to the U.S. Office of Personnel Management's Procurement Process for Benefit Programs in Washington, DC	October 14, 2015	1	4
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, DC	November 10, 2015	16	27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, DC	November 13, 2015	5	5
1A-10-17-14-037	Health Care Service Corporation in Chicago, Illinois	November 19, 2015	3	16

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CF-00-16-026	The U.S. Office of Personnel Management's Fiscal Year 2015 Improper Payments Reporting in Washington, DC	May 11, 2016	1	6
4A-CI-00-16-037	Second Interim Status Report on the U.S. Office of Personnel Management's Infrastructure Improvement Project - Major IT Business Case in Washington, DC	May 18, 2016	2	2
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, DC	July 8, 2016	6	6
1C-L4-00-I6-013	HMO Health Ohio in Cleveland, Ohio	September 23, 2016	2	2
4K-RS-00-16-023	The U.S. Office of Personnel Management's Retirement Services' Customer Service Function in Washington, DC	September 28, 2016	2	3
4A-CI-00-16-061	Web Application Security Review in Washington, DC	October 13, 2016	4	4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, DC	November 9, 2016	21	26
IA-10-33-15-009	Blue Cross and Blue Shield of North Carolina in Durham, North Carolina	November 10, 2016	4	6
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, DC	November 14, 2016	15	19
4A-RS-00-16-035	Information Security Controls of the U.S. Office of Personnel Management's Federal Annuity Claims Expert System in Washington, DC	November 21, 2016	5	13

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CF-00-17-012	The U.S. Office of Personnel Management's Fiscal Year 2016 Improper Payments Reporting in Washington, DC	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, DC	June 20, 2017	4	4
4A-OO-00-16-046	The U.S. Office of Personnel Management's Purchase Card Program in Washington, DC	July 7, 2017	10	12
4A-CF-00-17-043	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, DC	September 29, 2017	5	7
4A-CF-00-17-044	Information Technology Security Controls of the U.S. Office of Personnel Management's Federal Financial System in Washington, DC	September 29, 2017	7	9
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, DC	September 29, 2017	8	8
1H-01-00-16-044	Mail Handlers Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. for Contract Years 2012 through 2014 in Scottsdale, Arizona	October 2, 2017	1	3
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, DC	October 27, 2017	38	39

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-CF-00-17-033	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act in Washington, DC	November 9, 2017	3	3
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, DC	November 13, 2017	18	18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, DC.	January 16, 2018	20	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, DC	February 15, 2018	4	4
1A-99-00-16-021	Global Veterans Affairs Claims for Blue Cross and Blue Shield Plans in Washington, DC	February 28, 2018	5	5
4K-RS-00-17-039	The U.S. Office of Personnel Management's Retirement Services' Imaging Operations in Washington, DC	March 14, 2018	1	3
4A-MO-00-18-004	Information Technology Security Controls of the U.S. Office of Personnel Management's Combined Federal Campaign System in Washington, DC	March 29, 2018	2	5
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, DC	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, DC	May 10, 2018	1	2

APPENDIX VIII

Summary of Reports
More Than Six Months Old Pending Corrective Action
As of March 31, 2019
(Continued)

Report Number	Subject	Date Issued	Recommendations Open	Recommendations Total
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, DC	May 10, 2018	4	4
4A-CI-00-18-044	U.S. Office of Personnel Management's Fiscal Year 2018 IT Modernization Expenditure Plan in Washington, DC	June 20, 2018	2	2
4A-PP-00-18-011	Information Technology Security Controls of the U.S. Office of Personnel Management's Health Claims Data Warehouse in Washington, DC	June 25, 2018	2	12
4A-CF-00-17-050	U.S. Office of Personnel Management's Personnel Security Adjudications Process in Washington, DC	August 201, 2018	1	8
1A-99-00-17-048	Global Audit of Claims-to-Enrollment Match for Blue Cross and Blue Shield Plans in Washington, DC	August 28, 2018	1	7

APPENDIX IX

Most Recent Peer Review Results

As of March 31, 2019

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 National Science Foundation *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	December 14, 2017	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	Compliant

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

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

APPENDIX X

Investigative Recoveries
October 1, 2018 to March 31, 2019

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			**$15,637,267**	**$15,104,952**
	Healthcare and Insurance		$14,988,288	$14,455,973
		Collection of Improper Payments	$14,988,288	$14,455,973
	National Insurance Crime Bureau		$70,413	$70,413
		Contract Off-Sets	$70,413	$70,413
	Retirement Services		$578,566	$578,566
		Admin Debt Recoveries	$66,778	$66,778
		Bank Reclamations	$86,014	$86,014
		Identification of Improper Payments	$425,775	$425,775
Civil			**$58,465,477**	**$3,183,905**
	Healthcare and Insurance		$58,465,477	$3,183,905
		Civil Actions	$58,465,477	$3,183,905
Criminal			**$14,381,421**	**$867,234**
	Healthcare and Insurance		$13,871,797	$636,064
		Court Assessments/Fees	$0	$0
		Criminal Fines	$1,500	$0
		Criminal Judgments/ Restitution	$13,870,297	$636,064
	National Insurance Crime Bureau		$358,156	$189,093
		Court Assessments/Fees	$1,300	$0
		Criminal Judgments/ Restitution	$356,856	$189,093
	Retirement Services		$151,668	$42,077
		Court Assessments/Fees	$0	$0
		Criminal Judgments/ Restitution	$0	$0
Grand Total			**$88,484,165**	**$19,156,091**

Index of Reporting Requirements

(As per the Inspector General Act of 1978, As Amended)

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MARCH 2019
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