Office of the Inspector General

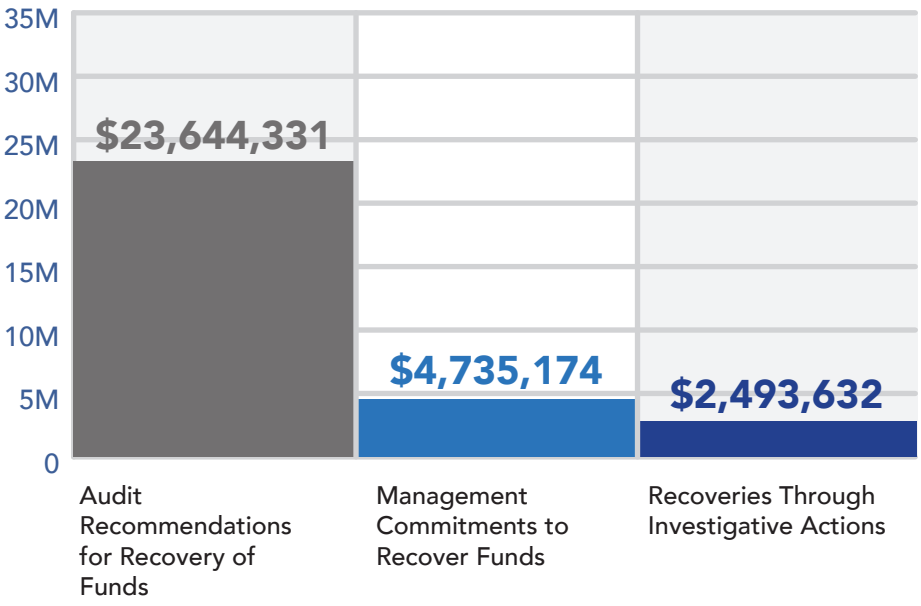
Semiannual Report to Congress

October 1, 2022 – March 31, 2023

United States Office of Personnel Management

Productivity Indicators

Financial Impact



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

Accomplishments

Audit Reports Issued	Evaluation Reports Issued	Data Briefs Issued	Management Advisories Issued	Investigations and Preliminary Investigations Closed	Indictments and Criminal Informations
16	1	1	0	76	11
3	18	1951	1404	530	1367
Arrests	Convictions	Hotline Contacts and Complaints Received	Hotline Contacts and Complaints Closed	Debarments and Suspensions of Federal Employees Health Benefits Program Providers	Debarment and Suspension Inquiries Regarding Federal Employees Health Benefits Program Providers

Message from the Inspector General

On behalf of the employees of the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG), I am pleased to submit this Semiannual Report highlighting our work between October 1, 2022, and March 31, 2023, as part of our mission to provide independent, transparent, and objective oversight of OPM programs and operations.

In our last Semiannual Report, I identified closing the hundreds of open recommendations from the OIG as one of my top priorities. During this reporting period, the OPM OIG for the first time identified three priority open recommendations. These recommendations cover the cost of prescription drugs, information security, and the cost of OPM's common services. We will continue to work with OPM to ensure that the agency acts to address open recommendations, including our priority open recommendations.

In February, the OIG released our Strategic Plan for Fiscal Years 2023–2028. One of the priority goals in the OIG's Strategic Plan is to develop the OPM OIG's data analytics program to improve our ability to build data-driven, evidence-based audit, evaluation, and investigation programs. With a recently modernized data warehouse in place, we are now making an initial investment in advanced data science technologies such as machine learning and artificial intelligence. We will continue to pursue additional resources to strengthen our oversight capabilities and performance on behalf of taxpayers. Enhancing our data analytics capabilities will strengthen our ability to conduct proactive oversight of OPM's programs and operations.

Additionally, proactive oversight is critical for the new Postal Service Health Benefits Program (PSHBP). The Postal Service Reform Act of 2022 requires OPM to establish the PSHBP within the Federal Employees Health Benefits Program (FEHBP) by January 2025. Proactive oversight of OPM's implementation of the PSHBP is essential to address this new program's challenges early — as they occur — and to prevent fraud, waste, and abuse.

The OIG released 16 final audit reports during the reporting period, which serve to document oversight of operations at both OPM and the FEHBP health plans. Our audits disclosed significant findings; in one example, an audit of an FEHBP health plan led to the return of over $1.7 million to the FEHBP. Another audit of FEHBP pharmacy operations led to the identification of over $15 million in overcharges by a health plan and a Pharmacy Benefit Manager.

Continuing our work on COVID-19's impact on the FEHBP and its enrollees, we issued a data brief on telehealth services and utilization. This data brief provides recommendations to OPM and its participating health insurance carriers on improvements that could be made, for example, to protect against fraud, while underscoring the importance of covering and paying for telehealth services appropriately, implementing adequate program safeguards, and ensuring quality of care.

We investigated a range of fraud, waste, and abuse allegations during the reporting period, including allegations related to COVID-19 testing or treatment. In an ongoing COVID-19 case from this semiannual reporting period, we investigated allegations that a doctor who owned a laboratory performed drive-through COVID-19 testing (that often lasted about 5 minutes) billed as if performing moderately complex patient visits. The doctor/owner has been indicted on multiple counts of health care fraud for these criminal allegations involving $1.46 million in FEHBP funds.[1]

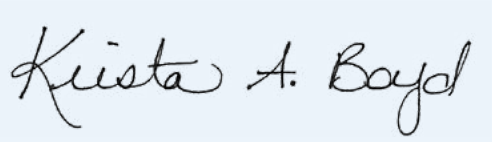
1 An indictment is merely an allegation. All defendants are presumed innocent until proven guilty beyond a reasonable doubt in a court of law.

Our work also continues to highlight concerns regarding ineligible enrollees in the FEHBP and allegations of OPM retirement program fraud, waste, and abuse. In an example of the impact of the OIG's work on behalf of Federal employees, annuitants, and their eligible family members, our investigators were able to get benefits restored for a disabled survivor annuitant.

The OIG also conducted an evaluation of OPM's Merit System Accountability and Compliance (MSAC) office which led to MSAC formalizing and documenting their internal quality control measures and processes for their evaluations work.

We issued 530 administrative sanctions (suspensions and debarments) of FEHBP health care providers who have committed a violation such as a criminal conviction based on delivery of, or payment for, health care services during this reporting period.

This Semiannual Report reflects the outstanding work of OIG personnel. The OIG remains committed to our mission to detect and deter waste, fraud, abuse, and misconduct related to OPM programs and operations and to promote economy and efficiency in those programs.



Krista A. Boyd
Inspector General

Mission

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

Vision

Oversight through Innovation.

Core Values

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

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OIG Office Locations

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

Audit Activities

Health Insurance Carrier Audits

The U.S. Office of Personnel Management (OPM) contracts with Federal Employees Health Benefits Program (FEHBP) carriers for health benefit plans for Federal employees, annuitants, and their eligible family members. The OPM Office of the Inspector General (OIG) 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 insurance audit universe encompasses over 200 audit sites consisting of health insurance carriers, sponsors, and underwriting organizations participating in the FEHBP. The number of audit sites fluctuates due to the addition, nonrenewal, and merger of participating health insurance carriers. Combined premium payments for the FEHBP total over $60 billion annually. The health insurance carriers audited by the OIG are classified as either community-rated or experience-rated.

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

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

Community-Rated 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 FEHBP carriers charge for health plans and the Medical Loss Ratios (MLRs) filed with OPM are in accordance with their respective contracts and applicable Federal laws and regulations.

Premium Rate Review Audits

Our premium rate review audits focus on the rates set by the carrier and ultimately charged to the FEHBP subscriber, the Federal Government, and taxpayers. When an audit shows that the rates are incorrect, unsupported, or inflated, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges. Any questioned costs related to the premium rates must be returned to OPM. Carriers must also return an additional amount intended to compensate for lost investment income.

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

- The medical and prescription drug claims totals are accurate and the individual claims are processed and paid correctly;
- The FEHBP rates are developed using a rating methodology that could be filed and approved with the appropriate State regulatory body or if not State-approved, is used in a consistent manner for all eligible community groups that meet the same criteria as the FEHBP; and
- The rate adjustments applied to the FEHBP rates for additional benefits not included in the basic benefit package are appropriate, reasonable, and consistent.

Medical Loss Ratio Audits

We also perform audits to evaluate carrier compliance with OPM's FEHBP-specific MLR requirements, which are based on the MLR standards established by the Affordable Care Act and which apply to most community-rated carriers. State-mandated traditional community-rated carriers are not subject to the MLR regulations and continue to be subject to the Similarly-Sized Subscriber Group comparison rating methodology.

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

The FEHBP-specific MLR requires carriers to report information related to earned premiums and expenditures in various categories, including reimbursements 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, which is ultimately distributed to the contingency reserve accounts of all health plans subject to the MLR rules. 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 present notable findings in audit reports of community-rated FEHBP carriers issued during this reporting period and also serve to highlight a common theme related to FEHBP enrollment and eligibility issues.

Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc.
Las Vegas, Nevada
Report No. 2022-CRAG-0010
February 15, 2023

We identified several issues with the termination of health benefits coverage for FEHBP members at the Health Plan of Nevada, Inc. (the Plan). These issues stemmed from a lack of internal controls over the process at the Plan as well as process deficiencies and administration issues at OPM.

Issues with properly terminating health benefits coverage and other enrollment process deficiencies at both the Health Plan of Nevada, Inc., and OPM increased the risk of improper payments and elevated risks related to FEHBP members' access to health benefits coverage.

Specifically, we determined that the Plan did not comply with the provisions of its 2016 through 2020 contracts with OPM due to insufficient internal controls over its termination of coverage process for FEHBP members and noncompliance with OPM's FEHBP enrollment regulations. As a result, the Plan terminated coverage for FEHBP members and their dependents without assessing and applying the 31-day extension of coverage (EOC) correctly and timely, which impacted members' access to health benefits coverage. Additionally, the Plan's systems could not discern FEHBP member eligibility and apply the applicable FEHBP coverage timeframe, potentially allowing dependents to maintain coverage after reaching age 26. The impact extended beyond the 5-year scope of the audit to all contract years during which the Plan's previous termination of coverage procedure remained in effect.

Based on our review, we determined that:

- Some FEHBP members did not receive the required 31-day EOC after their coverage was terminated;
- The Plan had insufficient FEHBP termination policies and procedures in place to effectively administer FEHBP enrollment in contract years 2016 through 2020;
- The Plan distributed conflicting disenrollment letters to some FEHBP members whose coverage was terminated;
- The Plan's data did not adequately support proper termination of coverage for FEHBP members' dependents; and
- Multiple errors, inaccurate data, and evidence of unsupported FEHBP dependent enrollments impacted the Plan's ability to meet the FEHBP enrollment Contract requirements.

The Plan agreed with the findings and has already taken action to address our recommendations.

During our review of the Plan's termination of coverage process, we also identified FEHBP enrollment process deficiencies and other program administration issues at OPM that impede the Plan's ability to comply with its contract, properly assess the appropriateness of coverage extensions, and resolve enrollment discrepancies. If left unaddressed by OPM, these issues enhance the risk of all FEHBP carriers improperly denying or paying claims for FEHBP dependent members.

As it relates to OPM, we determined the following:

- The enrollment file layout, standard enrollment forms, and corresponding Companion Guide issued by OPM do not include the necessary information required for carriers to determine the proper 31-day EOC application for certain dependent (e.g., spouse, children) coverage terminations, as required under the provisions of its contract with FEHBP carriers;
- OPM provided insufficient oversight and enforcement of the Centralized Enrollment Clearinghouse System process, resulting in excessive unresolved reconciliation issues and reporting errors that carriers are either unable to resolve or are not held accountable to resolve; and
- OPM did not post finalized enrollment guidance Carrier Letters on its website.

Humana Health Plan, Inc.
Louisville, Kentucky
Report No. 2022-CRAG-008
December 19, 2022

Portions of the Humana Health Plan's (the Plan) 2019 through 2021 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. As such, the Plan owes the FEHBP $334,761 for defective pricing in contract years 2020 and 2021 and $13,083 for lost investment income resulting from the premium overpayments.

The FEHBP is due $334,761 from Humana Health Plan for defective pricing in contract years 2020 and 2021 and $13,083 for lost investment income on premium overpayments.

We also determined that:

- The Plan did not maintain adequate supporting documentation for over age dependents, i.e., once they reach age 26, as required by applicable criteria;
- The Plan did not properly configure its claims system to price and pay claims based on the terms of the provider contracts and fee schedules;
- One claim was processed and paid with an incorrect Explanation of Medicare Benefits, and another claim was paid after a member's termination date; and
- The 2018 family rate for the standard option plan was incorrectly stated in the 2018 benefit brochure.

The Plan agreed with a majority of the findings and has already taken action to address our recommendations.

Humana Health Plan, Inc., announced on February 23, 2023, that it will no longer cover Employer Group Commercial Medical Products, which includes the FEHBP. The Plan will cease FEHBP operations on December 31, 2023, but will continue to process claims through the runout period.

Experience-Rated Carriers

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

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

During the current reporting period, we issued five final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP and one data brief regarding COVID-19's impact on FEHBP telehealth utilization and services. The five final audit reports contained recommendations for the return of over $8.1 million to the OPM-administered health care trust fund. The telehealth evaluation included five recommendations for FEHB program improvements.

Blue Cross Blue Shield Service Benefit Plan Audits

The Blue Cross Blue Shield Association (BCBS Association), on behalf of 60 participating health insurance plans offered by 34 BCBS companies, has a governmentwide Service Benefit Plan (SBP) contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBS Association delegates authority to participating local BCBS Plans throughout the United States to underwrite and process the health benefit claims of its Federal subscribers. Over 60 percent of all FEHBP subscribers are enrolled in the BCBS SBP.

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

The audits and data brief summarized below are representative of our oversight of experience-rated health plans.

Premera Blue Cross
Mountlake Terrace, Washington
Report No. 2022-ERAG-0011
December 12, 2022

Our multi-plan company audit of the FEHBP operations at Premera Blue Cross (Premera BC, or the Plan) covered the Plan's miscellaneous health benefit payments and credits (such as refunds and medical drug rebates), administrative expense charges, cash management activities and practices, and fraud and abuse program activities pertaining to Premera Blue Cross of Washington and Premera Blue Cross and Blue Shield of Alaska. We questioned $3,508,556 in health benefit charges, administrative expense overcharges, and lost investment income. Our most significant finding was that Premera BC, because of a lack of due diligence in their recovery efforts, had not recovered and/or returned $3,198,939 to the FEHBP for claim overpayments paid to Indian Health Service health care providers.

Premera BC agreed with $3,506,986 and disagreed with $1,570 of the questioned amounts. As part of our review, we verified that Premera BC returned $1,718,518 of the questioned amounts to the FEHBP. As of the time of this semiannual report to Congress, two monetary recommendations remain open for questioned charges of $1,492,251 and lost investment income of $1,570.

The audit disclosed no reportable findings pertaining to either (1) Premera BC's cash management activities and practices related to FEHBP funds or (2) Premera BC's fraud and abuse program activities. Overall, we determined that Premera BC handled FEHBP funds in accordance with their contract, applicable laws, and Federal regulations concerning cash management in the FEHBP. We also determined that Premera BC complied with the communication and reporting requirements for submitting fraud and abuse cases to the OIG.

Cash Management Activities and Aging Refunds for a Sample of Blue Cross and/or Blue Shield Plans
Washington, D.C.
Report No. 2022-ERAG-0012
December 13, 2022

Our focused audit of FEHBP operations at a sample of 22 BCBS plans covered the plans' cash management activities and practices, including aging health benefit refunds, related to FEHBP funds. The objectives of our audit were to determine if the 22 BCBS plans in our sample handled FEHBP funds, including aging FEP refunds, in accordance with Contract CS 1039 and applicable laws and regulations concerning cash management and health benefit refunds in the FEHBP.

We questioned $635,783 in cash management activities, aging FEP refunds, and lost investment income for six BCBS Plans. Our most significant finding was that Excellus BCBS held excess FEHBP funds totaling $320,392 in the dedicated FEP investment account. These excess FEHBP funds consisted of $304,451 in health benefit refunds and $15,941 in medical drug rebates. Excellus BCBS subsequently returned the full amount of the questioned excess funds to the FEHBP ranging from 70 to 634 days late.

The BCBS Association and applicable BCBS plans agreed with all the questioned amounts. As part of our review, we verified that the applicable BCBS plans returned the entire $635,783 to the FEHBP.

Audit of Claims Processing and Payment Operations at Premera Blue Cross for Contract Years 2018 through 2020
Washington, D.C.
Report No. 2022-CAAG-009
February 8, 2023

Our audit of the FEHBP claims processing and payment operations at Premera BC was performed to determine if the internal controls over its claims processing system were sufficient to ensure the proper processing and payment of health care claims. We identified 2,250 improperly paid claims resulting in FEHBP overpayments of $2,009,414. The claim payment errors indicate a need to strengthen procedures and controls related to:

- Incorrect bundling of ambulatory payment classification claims, which was caused by a system error that allowed individual claim lines to be paid when they were already bundled and paid on another claim line; and
- Duplicate claim payments.

The audit also identified a procedural issue related to member cost share overpayments. Specifically, Premera BC did not have procedures in place to correct claims when members were overcharged, notify the members of the overpayments, or direct their providers to reimburse the members.

The final report included two monetary and four procedural recommendations. The BCBS Association agreed to return any funds recovered to the FEHBP and is working with Premera BC to address the four procedural recommendations. It should be noted that our final report recommended the return of all amounts overpaid related to the incorrect bundling of ambulatory payment classification claims (totaling $1,944,914) regardless of the success of recovery efforts because Premera BC did not exercise due diligence in trying to identify the claims impacted by this error once it was identified. Instead, the improperly paid claims were not identified until the time of the audit.

Audit of Claims Processing and Payment Operations at Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020
Washington, D.C.
Report No. 2022-CAAG-0023
March 3, 2023

Our audit of the FEHBP claims processing and payment operations at Blue Cross and Blue Shield of North Carolina (BCBS of NC) was performed to determine if the internal controls over its claims processing system were sufficient to ensure the proper processing and payment of health care claims. We identified 5,102 improperly paid claims resulting in FEHBP overpayments of $1,948,361. The claim payment errors identified indicate a need to strengthen procedures and controls related to:

- Assistant surgeon procedure code modifiers. Claims with this type of procedure code modifier were not being paid at the correct reduced allowance due to a system pricing update error; and
- Duplicate claim payments.

The final report included two monetary and three procedural recommendations. The BCBS Association is working with BCBS of NC to identify all amounts overpaid, both within and outside of our audit scope, and to initiate recovery of the overpayments. They are also working with BCBS of NC to ensure the remaining recommendations are addressed.

BCBS of NC agreed with one of our monetary recommendations, which is now closed. They did not agree with the remaining four recommendations, which remain open.

Evaluation of COVID-19's Impact on Telehealth Services and Utilization
Washington, D.C.
Report No. 2022-CAAG-0014
March 6, 2023

The COVID-19 pandemic brought particular attention to telehealth as a means of limiting exposure to other individuals while receiving medical care, thereby minimizing the risk of contracting or spreading the virus. As such, telehealth utilization rates in the FEHBP increased more than 5,000 percent over the first 16 months of the COVID-19 pandemic and continue to be much higher than at any time pre-pandemic. Because of this major shift in the health care industry, we initiated a project to analyze utilization trends and program integrity risks in the telehealth space. We determined that:

- Some FEHBP carriers' claims processing systems do not perform edits or analytics to check for potentially fraudulent billing patterns providers may use to inappropriately maximize their FEHBP payments for telehealth services;
- OPM's Healthcare and Insurance office has not set limits on allowable telehealth procedures, increasing the risk that inappropriately billed procedures will go unidentified;
- There are very few controls in place to protect the confidentiality, integrity, and availability of the technologies used for telehealth sessions;
- Some carriers have no controls over recording audio or video during telehealth visits; and
- Some carriers do not educate FEHBP members or providers on telehealth privacy and security risks.

The final data brief included five procedural recommendations, offering OPM and FEHBP-participating health insurance carriers insights for improving telehealth policies and procedures. The final data brief also underscores the importance of covering and paying for telehealth services appropriately, implementing adequate program safeguards, and ensuring quality of care.

OPM disagreed with all five recommendations and they remain open.

Information Systems Audits

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

Our audit universe encompasses all 51 OPM-owned information systems as well as the 68 information systems used by private sector entities that contract with OPM to process FEHBP data. We issued four IT system audit reports during the reporting period. Selected notable reports are summarized below.

Federal Information Security Modernization Act Audit for Fiscal Year 2022
Washington, D.C.
Report Number 2022-ISAG-0017
November 16, 2022

The Federal Information Security Modernization Act (FISMA) Inspector General reporting metrics use a maturity model evaluation system derived from the National Institute of Standards and Technology's Cybersecurity Framework. The Cybersecurity Framework is comprised of nine "domain" areas, and the weighted averages of the domain scores for these nine areas are used to derive the agency's overall cybersecurity score. In fiscal year (FY) 2022, OPM's cybersecurity maturity level was measured as "3 – Consistently Implemented."

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

- **Risk Management** – OPM has defined an enterprise-wide risk management strategy through its Risk Management Council. OPM is working to implement a comprehensive inventory management process for its hardware and software inventories.
- **Supply Chain Risk Management** – OPM's Supply Chain Risk Management program is ad hoc and needs to be developed.
- **Configuration Management** – OPM continues to develop baseline configurations and approve standard configuration settings for its information systems. The agency has an established configuration change control process.
- **Identity, Credential, and Access Management** (**ICAM**) – OPM is continuing to develop its agency ICAM strategy. OPM has enforced multifactor authentication with Personal Identity Verification cards.

- **Data Protection and Privacy** – OPM has defined controls related to data protection and privacy, including data exfiltration prevention. However, the Data Breach Response Plan has not been updated or tested.

- **Security Training** – OPM has implemented a security training strategy and program. OPM has performed a workforce assessment to identify the skill gaps for the agency's cybersecurity workforce.

- **Information Security Continuous Monitoring** – OPM has established many of the policies and procedures surrounding continuous monitoring, but the agency has not consistently implemented all the Information Security Continuous Monitoring policies. OPM should continue to improve its process for conducting security controls assessments on all its information systems.

- **Incident Response** – OPM has implemented many of the required controls for incident response. Based on our audit work, OPM has successfully implemented all the FISMA incident response metrics at the level of Managed and Measurable.

- **Contingency Planning** – OPM has not implemented several of the FISMA requirements related to contingency planning and needs to improve upon maintaining its contingency plans and conducting contingency plan tests on a routine basis.

OPM agreed with 26 of our 29 recommendations.

Audit of the Information Systems General and Application Controls at American Postal Workers Union Health Plan
Glen Burnie, Maryland
Report Number 2022-ISAG-0024
February 27, 2023

Our IT audit focused on the claims processing applications used to adjudicate FEHBP claims for American Postal Workers Union Health Plan (APWUHP) members and the various processes and IT systems used to support these applications. Our audit of the IT security controls of APWUHP determined that:

- APWUHP addressed risks they had identified and began conducting ongoing vendor risk assessments;

- APWUHP has adequate physical and logical access controls in place;

- APWUHP has not performed adequate vulnerability scans for all assets in its IT environment resulting in systems with technical weaknesses and known exploits;

- APWUHP does not have adequate controls in place related to internal network segmentation and reviewing audit logs;

- APWUHP has not developed baseline or security configuration settings for all operating systems and does not have a process in place to monitor security configurations;

- APWUHP implemented controls related to testing environments, software management, and assessing impacts for IT-related changes;

- APWUHP developed business-area recovery metrics and conducted an incident response test; however, it does not have sufficient controls in place for event monitoring and adequate vulnerability scanning is not conducted at the backup data center; and

- APWUHP does not have adequate controls in place related to developer security standards and training.

APWUHP agreed with all of the recommendations in our report and has taken action to address our recommendations.

Internal Audits

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

OPM's Consolidated Financial Statements Audits

The Chief Financial Officers Act of 1990 (Public Law 101–576) requires OPM's Inspector General or an independent external auditor, as determined by the Inspector General, to audit the agency's financial statements in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. OPM contracted with Grant Thornton LLP, an independent certified public accounting firm, to audit OPM's consolidated financial statements as of September 30, 2022, and September 30, 2021. The contract required that the audit be performed in accordance with Generally Accepted Government Auditing Standards (GAGAS) and U.S. Office of Management and Budget (OMB) Bulletin No. 22-01, *Audit Requirements for Federal Financial Statements*.

OPM's consolidated financial statements include the agency's Retirement Program, Health Benefits Program, Life Insurance Program, Revolving Fund Programs, and Salaries and Expenses funds. OPM provides a variety of human resource-related services to other Federal agencies, such as preemployment testing and employee training, and these activities are financed through an intragovernmental revolving fund. The Salaries and Expenses funds provide the budgetary resources used by OPM for administrative purposes in support of the agency's mission and programs.

Grant Thornton was responsible for, among other things, issuing an audit report that included:

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

In connection with the audit contract, we reviewed Grant Thornton's report and related documentation and made inquiries of its representatives regarding the audit. To fulfill our audit responsibilities under the Chief Financial Officers Act for ensuring the quality of the audit work performed, we conducted a review of Grant Thornton's audit of OPM's FY 2022 Consolidated Financial Statements in accordance with *Government Auditing Standards*. Specifically, we:

- Provided oversight, technical advice, and liaison services to Grant Thornton auditors;
- Ensured that audits and audit reports were completed timely and in accordance with the requirements of GAGAS, OMB Bulletin 22-01, and other applicable professional auditing standards;
- Documented oversight activities and monitored audit status;

- Reviewed responses to audit reports and reported any significant disagreements to the audit follow-up official per OMB Circular No. A-50, Audit Follow-up;
- Coordinated issuance of the audit report; and
- Performed other procedures we deemed necessary.

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

Grant Thorton's audit of OPM's FY 2022 Consolidated Financial Statements is summarized below.

OPM's FY 2022 Consolidated Financial Statements
Washington, D.C.
Report No. 2022-IAG-003
November 14, 2022

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

- The consolidated balance sheets as of September 30, 2022, and September 30, 2021;
- The related consolidated statements of net cost, changes in net position, and the combined statements of budgetary resources for the years then ended;
- The related notes to the consolidated financial statements;
- The individual balance sheets of the Retirement, Health Benefits, and Life Insurance programs (hereafter referred to as "the Programs"), as of September 30, 2022, and September 30, 2021;
- The related individual statements of net cost, changes in net position, and budgetary resources for the years then ended; and
- The related notes to the individual financial statements.

Grant Thornton reported that OPM's consolidated financial statements and its Programs' individual financial statements as of and for the fiscal years ended September 30, 2022, and September 30, 2021, were presented fairly in all material respects and in conformity with GAGAS. Grant Thornton's audit objectives include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

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

Information Systems Control Environment continues to be a material weakness in FY 2022.

Information Systems Control Environment—During FY 2022, deficiencies noted in FY 2021 continued to exist, and Grant Thornton's testing identified similar control issues in both the design and operation of key controls. Grant Thornton believes that, in many cases, these deficiencies continue to exist because of one, or a combination, of the following:

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

The information system issues identified in FY 2022 included repetitive conditions consistent with prior years, as well as new deficiencies. The deficiencies in OPM's information systems control environment are in the areas of Security Management, Logical Access, Configuration Management, and Interface/Data Transmission Controls. In the aggregate, these deficiencies are considered to be a material weakness. OPM concurred with the findings and recommendations reported by Grant Thornton.

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

Special Audits

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

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

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

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

Audit of Blue Cross Blue Shield Association's
Service Benefit Plan's Specialty Drug Pharmacy Program
as Administered by Prime Therapeutics, LLC
Contract Years 2018 through 2021
Jacksonville, Florida, and Cranberry Township, Pennsylvania
Report Number 2022-SAG-0025
October 27, 2022

We completed a performance audit of the BCBS Association's Service Benefit Plan's Specialty Drug Pharmacy Program as administered by Prime Therapeutics, LLC (Prime), for the FEHBP. Our audit consisted of a review of the administrative fees, annual accounting statements, claims processing (including eligibility and pricing), drug manufacturer rebates, fraud and abuse program, and performance guarantees for specialty drug pharmacy operations during contract years 2018 through 2021.

The objective of the audit was to determine whether costs charged to the FEHBP and services provided to its members were in accordance with OPM Contract Number CS 1039 (Contract), the Pharmacy Benefit Management Agreement (Agreement), and applicable Federal regulations.

The audit found that BCBS Association and Prime properly administered pharmacy operations for specialty drugs over the scope of the audit. There were no audit findings related to this review. As a result, we determined that the costs charged to the FEHBP and services provided to its members were in accordance with the terms of the Contract, the Agreement, and applicable Federal regulations.

BCBSA and Prime properly administered FEHBP pharmacy operations for specialty drugs over the scope of the audit.

Audit of Group Health Incorporated's
FEHBP Pharmacy Operations as Administered by Express Scripts, Inc.
Contract Years 2015 through 2019
Jacksonville, Florida, and Cranberry Township, Pennsylvania
Report Number 1H-08-00-21-015
February 16, 2023

We completed a performance audit of Group Health Incorporated's (GHI's) FEHBP pharmacy operations as administered by Express Scripts, Inc. (ESI). Our audit consisted of reviewing the administrative fees, annual accounting statements, claims eligibility and pricing, drug manufacturer rebates, performance guarantees, and fraud and abuse program for pharmacy operations during contract years 2015 through 2019.

The audit found that GHI and ESI overcharged the FEHBP $15,086,271 (when amounts attributed to lost investment income are also considered) by not passing through all discounts and credits related to prescription drug pricing required under the PBM Transparency Standards found in GHI's contract with OPM. Specifically, our audit identified six findings that require corrective action. The findings occurred across all years of the audit scope and each amount includes lost investment income.

- The FEHBP did not receive pass-through transparent drug pricing from ESI, resulting in a total overcharge of $12,480,345 to the program.
- The FEHBP did not receive any of the drug purchasing discounts collected by ESI for drugs filled at ESI's own specialty and mail-order pharmacies, resulting in a $917,373 overcharge to the program.
- GHI failed to return $588,565 to the FEHBP for its portion of the PBM's generic drug pricing guarantees that ESI paid to GHI.
- The FEHBP did not receive all drug manufacturer rebates and corresponding administrative fees collected by ESI, resulting in a $1,048,407 overcharge to the program.
- GHI failed to return $51,581 for the FEHBP's portion of ESI's performance guarantee penalties that were credited back to GHI.
- GHI did not refer pharmacy-specific fraud and abuse cases to the OPM OIG because there was no process in place to identify which cases from ESI had FEHBP exposure.

No findings were identified from our reviews of the administrative fees, annual accounting statements, and claims eligibility.

GHI and ESI agreed with 2 of the 12 recommendations included in this report. Therefore, 10 of these recommendations remain open.

GHI and ESI overcharged the FEHBP $15,086,272 by not providing transparent, pass-through drug pricing.

Enforcement Activities

Investigative Activities

The OPM OIG Office of Investigations' mission is to protect Federal employees, annuitants, and their eligible family members and OPM programs from fraud, waste, abuse, and mismanagement by conducting criminal, civil, and administrative investigations related to OPM programs and operations. The Office of Investigations prioritizes investigations into allegations of harm against OPM program enrollees or annuitants, the substantial loss of taxpayer dollars, and agency program vulnerabilities that allow fraud, waste, and abuse. Our investigations safeguard the financial and program integrity of more than $156 billion in benefits distributed annually through the Civil Service Retirement System (CSRS), Federal Employees Retirement System (FERS), FEHBP, and FEGLI programs. More than 8 million current and retired Federal civilian employees and eligible family members receive benefits through these programs.

In this semiannual report to Congress, we present challenges to our oversight efforts, trends and areas of focus for our oversight activities, and selected cases representative of our investigative efforts and successes.[2]

Our investigations during this semiannual reporting period cover many different types of allegations and highlight the diversity of the OPM OIG's investigative work. The cases summarized in this section describe white-collar health care and retirement fraud schemes. The subjects of our investigations include medical providers, medical device manufacturers, and others. Some allegations relate to the COVID-19 pandemic or other nationwide health care issues. In addition, our selected cases show our investigative efforts related to priority issues affecting OPM programs. This includes thefts of payments intended for OPM annuitants and survivor annuitants.

The FEHBP is the largest employer-sponsored health program in the world and one of the most important and significant benefits provided to Federal employees, retirees, and their families. Improper payments, whether from fraud, waste, or abuse, can raise FEHBP costs and result in higher premium rates. Health care fraud that affects the FEHBP—whether by unscrupulous medical providers, medical companies, or even FEHBP members—risks physical and financial harm to patients or financial harm to the program. Our investigations help OPM and its contracted health insurance carriers provide trustworthy services to Federal employees, retirees, and their eligible family members and end schemes that annually cause millions of dollars in improper payments.

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

FEHBP Health Care Fraud Case Summaries

We present below selected health care fraud, waste, and abuse schemes that reached investigative or administrative milestones during this semiannual reporting period. Health care investigations comprise most of the OPM OIG's investigative portfolio and span a range of health care-related allegations involving providers, medical companies, and even FEHBP enrollees. Notably, in this semiannual reporting period we present multiple cases with allegations related to schemes that leveraged the COVID-19 pandemic. We previously identified that the pandemic's rapid changes to the health care environment created vulnerabilities for bad actors to exploit. We are encouraged that some of our investigations hold accountable those who wasted or stole taxpayer dollars during the COVID-19 pandemic.

Laboratory Returns FEHBP Dollars Paid for COVID-19 Testing

In June 2021, we received referrals from multiple FEHBP health insurance carriers about a medical testing lab that allegedly provided medically unnecessary COVID-19 testing to FEHBP members. The allegations in the referrals identified three types of potentially problematic testing scenarios: providing unnecessarily upgraded polymerase chain reaction (PCR) tests; providing several different types of tests (e.g., antibody, antigen, and PCR) on the same date of service; and providing tests to fully vaccinated FEHBP members. Our law enforcement team investigated all three allegations. The testing lab and the OPM OIG's Office of Legal and Legislative Affairs reached an administrative settlement that reimbursed $35,065 to the FEHBP.

Cochlear Implant Manufacturer Settles Over Falsified Testing Allegations

In September 2019, we received a *qui tam* complaint filed in the U.S. District Court for the Eastern District of Pennsylvania alleging that a medical company that manufactured and sold cochlear implant systems violated the False Claims Act. Specifically, it was alleged that between January 2011 and December 2019 the medical company knowingly submitted false or fraudulent claims to Federal health care programs because certain processors did not meet internationally recognized standards for radio frequency (RF) emissions, despite the company's representations that the devices met those standards.

The medical company allegedly failed to honor the standard's requirements to test processors using "worst-case" configurations and improperly shielded certain emissions-generating system components during emissions testing. Federal health care programs, including the FEHBP, paid for devices sold under these false claims. The RF emissions had the potential to interfere with other objects using RF in the vicinity of the cochlear implant systems, such as cell phones and other electronic devices.

Between July 2015 and July 2020, the FEHBP had paid $1.73 million to the medical company.

In a settlement agreement that denied the allegations and did not admit to liability, the medical company agreed to pay $11.36 million to the Federal Government to resolve the allegations. The FEHBP received $66,943 in restitution, as well as $10,958 in lost investment income and $13,647 in investigative costs. The FEHBP received $91,548 in total. The company also entered into a 5-year Corporate Integrity Agreement with the U.S. Department of Health and Human Services OIG. Per the Corporate Integrity Agreement, the company will face additional oversight and be required to implement, among other things, a risk assessment program.

Medical Practice Allegedly Upcoded COVID-19 Testing in Health Care Fraud Scheme

In March 2022, we received a referral from a Federal law enforcement partner about a medical practice that allegedly used COVID-19 coding claims improperly to maximize reimbursement.

The medical practice provided drive-through COVID-19 testing. Allegedly, as part of the testing, the medical practice billed each patient for receiving COVID-19 testing and for a moderately complex office visit. Specifically, the practice billed for Level 4 Evaluation & Management visits, which generally last between 30 and 39 minutes for existing patients and between 45 and 59 minutes for new patients. The doctor/owner of the medical practice is alleged to have known that many of the at-issue visits actually lasted 5 minutes or less.

Between January 2020 and January 2022, FEHBP carriers paid $1.46 million to the medical practice.

In April 2022, a Federal grand jury in the U.S. District Court for the District of Maryland indicted the doctor/owner of the medical practice on three counts of health care fraud. They pleaded not guilty.[3]

On January 11, 2023, a superseding indictment charged the doctor/owner with five additional counts of health care fraud related to services at COVID-19 test sites operated by the doctor/owner that billed Federal health programs, including the FEHBP, for Evaluation & Management services that were allegedly medically unnecessary, not provided as represented, or ineligible for reimbursement. The trial is currently scheduled to take place in a future reporting period. This indictment is an allegation; the doctor/owner is presumed innocent until proven guilty through the judicial process.

Doctor Pleads Guilty to Health Care Fraud for Ghost Patient Visits and Travel Claims

We received a case notification from an FEHBP health insurance carrier in January 2021 about a doctor allegedly billing for "travel claims," which were services billed when the doctor was actually out of State, and "ghost patient visits," which involved submitting billing claims as if multiple procedures were performed on different days when the procedures were actually performed on a single day of service.

Per a criminal information filed in the U.S. District Court in the Northern District of Illinois, some procedures were also medically unnecessary.

FEHBP carriers improperly paid the provider $42,919.

On March 2, 2023, the doctor pleaded guilty to one count of health care fraud. Sentencing is scheduled for a future semiannual reporting period.

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

FEHBP Member Allegedly Submits False Claims for Reimbursement

In September 2020, we received a referral from an FEHBP health insurance carrier about a member potentially receiving reimbursement for fictitious claims submitted on behalf of their dependent children. Our investigation identified $361,037 paid to the member for services that allegedly never occurred. According to our investigation, the FEHBP member submitted claims for reimbursement from an out-of-network mental health provider who had treated the dependent children before, but at least some of the submitted claims were inflated or referenced dates when the children did not see the provider.

An FEHBP member allegedly submitted false claims on behalf of his dependent children and received more than $361,000 from the FEHBP.

The FEHBP member was indicted on November 29, 2022, in the U.S. District Court for the Southern District of New York for health care fraud and aggravated identity theft.

OPM OIG Investigative Special FEHBP Topics

The FEHBP's Exclusion from the Anti-Kickback Statute

Among the ongoing challenges to the Office of Investigations' efforts to protect the FEHBP is the FEHBP's continued Anti-Kickback Statute (Title 42 United States Code (U.S.C.) § 1320a–7b) exclusion. The Anti-Kickback Statute makes it illegal for health care providers to knowingly and willfully accept bribes or other remuneration in exchange for business. The Anti-Kickback Statute's exclusion of the FEHBP continues to interfere with OPM recovering funds in cases involving common health care fraud criminal investigations and civil settlements. It also fails to provide OPM an alternative path for recourse.

The investigations described below were referred to our office during this reporting period. These cases represent how the Anti-Kickback Statute's exclusion of the FEHBP continues to seriously affect our office and stop the return of taxpayer dollars.

Overbilling Allegations ($545,201) Excluded by Anti-Kickback Statute

On November 21, 2022, we received a *qui tam* filed in the U.S. District Court for the Middle District of Tennessee that alleged a durable medical equipment company overbilled for its product, intentionally failed to report this overbilling, and submitted fraudulent or forged patient documentation. Investigative analysis of FEHBP claims found that the program paid $545,201 to the durable medical equipment company between 2019 and 2022.

The U.S. Department of Justice (DOJ) determined that the allegations in this case primarily related to the Anti-Kickback Statute. Because the FEHBP is excluded from investigations and settlements under that statute, we closed our investigation without further action.

$1.79 Million Loss Excluded by Anti-Kickback Statute

On October 14, 2022, we received a *qui tam* filed in the U.S. District Court for the Northern District of Texas that, among other things, alleged a diagnostics lab submitted claims for unnecessary molecular urinary tract infection testing and engaged in kickback schemes with referring physicians and practice groups to induce providers to refer patients to their specific diagnostics lab. The FEHBP had paid this provider $1.79 million for procedural codes associated with the allegations. On February 6, 2023, DOJ informed us that the investigation would focus on the alleged kickback scheme. Because the FEHBP is excluded from the Anti-Kickback Statute, we closed our case without further action or recovery of any of the $1.79 million.

OPM Retirement Program Fraud Case Summaries

According to OPM, improper payments affecting OPM retirement programs were $325.81 million in FY 2022. Our investigations into allegations of OPM retirement program fraud, waste, and abuse recover funds and help end ongoing improper payments by these programs.

The Office of Investigations also conducts proactive investigative activities that uncover improper payments. These cases can lead to OPM OIG criminal or civil investigations or OPM administrative actions. Our investigations sometimes help living OPM annuitants receive money they are owed or have a representative payee appointed to help appropriately manage their funds if the annuitant cannot. An example of such a case is described on page 31.

When fraud, waste, and abuse involve living OPM retirement annuitants or survivor annuitants, those crimes target a vulnerable population. Financial elder abuse is a common type of fraud that we investigate. And thefts of Government money involving deceased OPM annuitants often involve individuals who have stolen OPM annuity payments for years or even decades.

The following case summaries are representative of our oversight work this reporting period.

Daughter Pleads Guilty to Theft of Nearly 14 Years of Retirement Payments

In November 2020, we received a fraud referral from OPM's Retirement Services program office regarding the unreported December 2005 death of a retired OPM annuitant. OPM did not learn of the death until September 2019. In those nearly 14 years, OPM improperly paid $408,183 into the deceased annuitant's account.

Our investigation found that the deceased annuitant's adult daughter had been using the OPM annuity deposited into her deceased parent's account. Handwriting samples from the daughter analyzed by the Federal Bureau of Investigation laboratory confirmed that she had endorsed multiple checks not intended for their use.

Over the course of almost 14 years, the daughter of a deceased OPM annuitant stole $408,183.

During our investigation, OPM was able to recover $76,500 through Treasury's reclamation process and was internally credited $1,399. The remaining OPM overpayment totaled $330,283.

In August 2021, the case was accepted for prosecution by the U.S. Attorney's Office for the Eastern District of North Carolina. On November 2, 2022, the daughter pleaded guilty to one count of theft of Government funds. Further judicial action related to sentencing and court-ordered restitution is still pending.

One Individual Pleads Guilty, One Goes to Trial Over $420,000 Annuity Theft

In October 2019, we received a referral from a Federal law enforcement partner about a deceased OPM survivor annuitant whose May 2008 death was not reported to OPM. Payments from OPM continued through November 2019, resulting in an overpayment of $428,410. OPM recovered $940 through Treasury's reclamation actions.

Following the 2021 arrest of two individuals related to the theft of the annuity, one of the individuals pleaded guilty in the U.S. District Court for the District of Maryland on December 9, 2022. According to the plea agreement's Statement of Facts, between June 2008 and January 2020, this individual received the deceased survivor annuitant's CSRS payments and Social Security survivor benefit payments. From both programs, the amount stolen totaled over $470,000. The stolen funds were used for living expenses, retail purchases, and mortgage payments. The second arrested individual allegedly spent more than $30,000 on retail purchases and travel expenses.

As part of the one individual's guilty plea, the court ordered restitution of $470,173. Further judicial action related to sentencing, as well as any legal outcomes for the second individual, will occur in a future reporting period.

Proactive Investigation Restores Annuity to Disabled Survivor Annuitant

Our proactive investigative efforts discovered a disabled survivor annuitant with two survivor annuities. One annuity payment was suspended and the other was active.

We notified the Retirement Services program office of our findings in February 2022. The program office reviewed the information we provided and found that for one of the disabled survivor annuitant's cases, the agency received a response to their annual representative payee survey, but the second case had the survey returned as undeliverable. Based on that, the cases were put into different statuses. In June 2022, the Retirement Services program office learned that the disabled survivor annuitant had moved to a different rehabilitation center. The program office worked with that center to establish the new center as the new representative payee for the disabled survivor annuitant.

The Retirement Services program office confirmed that survivor annuity benefits from both deceased parents can be paid to a disabled-child survivor annuitant. The program office restored benefits for the suspended survivor annuitant and updated the representative payee to the rehabilitation facility where the disabled survivor annuitant lives. In November 2022, the Retirement Services program office authorized two payments totaling $7,325 to the disabled survivor annuitant.

Agency Oversight and Integrity Investigations

One of the fundamental duties of the OIG is to investigate allegations of fraud, waste, abuse, and misconduct within OPM, its programs, and its related contracts. This can involve investigations of administrative issues that affect OPM employees or contractors. As per the Inspector General Act of 1978, as amended, we must report to Congress in the Semiannual Report the outcomes of investigations of allegations involving senior positions within OPM.

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

During this reporting period, we have no integrity-related investigations that have reached a reportable milestone.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (Title 5 U.S.C. § 8902a), we suspend or debar health care providers whose actions demonstrate that they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were a total of 38,445 active suspensions and debarments which prevented health care providers from participating in the FEHBP.

> **Debarment** disqualifies a health care provider from receiving payment of FEHBP funds for a stated time period. The FEHBP has 18 bases for debarment. The most frequently cited provisions are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives the provider notice and the opportunity to contest the sanction in an administrative proceeding.
>
> **Suspension** has the same effect as a debarment but it becomes effective upon issuance without prior notice or process and remains in effect for a limited time. The FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.

During the reporting period, our office issued 530 administrative sanctions, including both suspensions and debarments, of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we responded to 1,367 sanctions-related inquiries.

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

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

Administrative sanctions serve two important functions. First, they protect the financial integrity of the FEHBP. Second, they protect the health and safety of Federal employees and annuitants (and these individuals' FEHBP-enrolled family members).

The following cases handled during the reporting period highlight the importance of the Administrative Sanctions Program Group (ASG).

Florida Acupuncturist Debarred After Surrendering License

In March 2023, our office debarred a Florida acupuncturist who voluntarily surrendered his license in lieu of disciplinary actions. The State of Florida Board of Acupuncture (Board) initiated a complaint after the acupuncturist was arrested for sexually battering a woman during an acupuncture session.

The Board found that the acupuncturist exercised influence within the patient–acupuncturist relationship for purposes of engaging a patient in sexual activity. He was charged with one count of sexual battery and two counts of battery.

Federal regulations state that OPM may debar providers of health care services from participating in the FEHBP whose license to provide a health care service has been revoked, suspended, restricted, or not renewed by a State licensing authority for reasons relating to the provider's professional competence, professional performance, or financial integrity. Accordingly, our debarment of the acupuncturist will remain in effect for an indefinite period pending the resolution of his medical license and outcome of his trial. This case was referred to our office by BCBS.

Virginia Counselor Sanctioned for Health Care Fraud Related Activity

In March 2023 our office debarred a licensed professional counselor (LPC) and her clinic after she was convicted in the U.S. District Court for the Eastern District of Virginia for violations of the following:

- Counts 1–40, Health Care Fraud (18 U.S.C. § 1347); and
- Counts 41–52, Fraud and Related Activity (18 U.S.C. § 102A(a)(1)).

The LPC owned and operated a center for integrative behavioral health and medicine with a focus on weight management issues. From January 2018 through February 2020, she executed a scheme to defraud and overbill various health care benefit programs and Medicaid. This scheme involved charging for 45 minutes to an hour of face-to-face psychotherapy services for non-clinical services like sending messages through the company's smartphone app or monitoring a client's data. The LPC billed these psychotherapy services for times when she was out of the country or on vacation and when the clients were out of State or hospitalized.

The LPC also defrauded health care programs and the Government by submitting false claims and engaging in multiple overbilling schemes. She used the names, Medicaid ID numbers, and other identifying information of her clients in submitting these false claims to health care benefit programs. She received at least $2,189,342 in fraudulent health care reimbursements from both Government and private insurers.

In April 2022, she pleaded guilty to the charges in the criminal information and the court's acceptance of the plea was issued the same day. On October 25, 2022, she was sentenced to 7 years in prison and 3 years of supervised release and ordered by the court to pay $2,266,209 in restitution. Our debarment is for 10 years to cover the duration of her prison term and supervised release. This case was referred to our office by BCBS.

New Jersey Rheumatologist Debarred for Conviction of Remuneration for Health Care Referrals

In February 2023, our office debarred a New Jersey rheumatologist based on her conviction in the U.S. District Court for the District of New Jersey for conspiracy to commit health care fraud.

According to court documents and evidence presented at trial, the physician owned and operated a rheumatology practice in Clifton, New Jersey. From 2010 through 2019, she billed Medicare and other health insurance programs $160 million for expensive infusion medications that her practice never purchased. She also fraudulently billed millions of dollars for allergy services that patients never needed or received. She was convicted of one count of conspiracy to commit health care fraud (a violation of 18 U.S.C. § 1349) and five counts of health care fraud (18 U.S.C. § 1347). She was sentenced to 21 months in prison and two years of supervised release, and the court ordered her to pay $2,418,769 in restitution. In addition, the health care facility owned by the physician was debarred.

Under the FEHBP's administrative sanctions statutory authority, a conviction constitutes a mandatory basis for debarment. We debarred the provider for 3 years. This case was referred to our office by BCBS.

California Resident Debarred for Health Care Related Conviction

Our office debarred a California resident based on his conviction for health care related fraud in the U.S. District Court for the Central District of California.

In December 2020, our office suspended the California resident based on his June 2018 indictment filed with the court.

A "suspension" is a temporary action pending the completion of an investigation or ensuing criminal, civil, or administrative proceeding that is:

- Effective immediately upon issuance of notice by OPM;
- Predicated on one or more of the bases for debarment identified in 5 U.S.C. § 8902a;
- Necessitated by the existence of a sufficiently serious risk to warrant removing a provider from the FEHBP in the most expeditious manner possible; and
- Makes the provider ineligible to receive payments of FEHBP funds for items or services furnished after the effective date, similar to a debarment.

Our office obtained information demonstrating that the resident was the beneficial owner of a now-dissolved pharmacy through which he fraudulently solicited prescriptions from insured individuals and through which he received kickbacks. In September 2021, he entered into a plea agreement in which he pleaded guilty to charges pertaining to tax evasion.

According to the plea agreement, the resident admitted that in or about March 2015, he entered into an agreement with a pharmacy owner to receive payment for the referral of compounded medication prescriptions. The payments were made to an account in the name of another person for the purpose of evading and defeating the assessment of Federal income taxes. The resident knew that he was required to file a Federal income tax return and to report the transfer of such funds to such "nominee accounts" as personal income. From approximately March 2015 through June 2015, the resident caused an estimate of $304,631 to be transferred to one such nominee account. He and the account holder understood and agreed that these funds were the resident's sole property,

over which he exercised control, and that he could direct how the money was to be used. He in fact directed that the funds be used for his own personal expenses.

In February 2022, the resident was convicted of tax evasion and sentenced to 12 months and 1 day of imprisonment, followed by a 2-year supervised released. In addition, he was ordered by the court to pay restitution in the amount of $100,919.

Under 5 U.S.C. § 8902a(b)(1), OPM has the authority to debar any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply.

The acts that led up to the resident's conviction were related to the delivery of health care services and/or supplies. Under the FEHBP's administrative sanctions authority, a conviction constitutes a mandatory basis for debarment. Therefore, the debarment of the resident was required based on his February 2022 conviction. His debarment took effect on October 5, 2022, and will run for a minimum mandatory period of 3 years.

This case was identified by the ASG.

Health Care Clinic Office Manager Debarred for Health Care Fraud

Our office debarred a California resident based on her conviction related to the delivery of health care services and/or supplies.

In January 2021, our office suspended the California resident based on her May 2018 indictment filed with the U.S. District Court for the Central District of California. Our office obtained information demonstrating that the California resident was an office manager of a health clinic which was used in a health care scheme to fraudulently bill health insurance companies for unnecessary medical services and for services that were never provided.

Documentation presented during trial provided evidence that from approximately January 2012 through approximately April 2017 the health care clinic office manager and others knowingly conspired and agreed to commit health care fraud in violation of 18 U.S.C. § 1347. The conspiracy resulted in approximately $8 million in health insurance claims. Of this amount, approximately $201,738 was paid to health clinics as a result of claims submitted to the FEHBP.

The health care clinic office manager induced health insurance beneficiaries to visit the clinics to receive cosmetic procedures, informing patients that they could receive free or discounted procedures if they provided their insurance information to the clinics. With the information she received from the beneficiaries, she would submit or cause the submission of false and fraudulent claims for reimbursement for medical services to health insurance companies. In addition, she would submit or cause to be submitted false and fraudulent claims to health insurance companies for unnecessary medical procedures or procedures that were never rendered. After the health insurance companies would issue payment based on the false and fraudulent claims, the health care clinic office manager would calculate a "credit" which would be a portion of the amount that the health insurance companies paid and give the credit to the beneficiaries to use to receive free or discounted cosmetic procedures from the health care clinic.

As part of the scheme, doctors were recruited to work part-time at the health care clinic. Bank accounts were opened by a codefendant who changed the recruited doctors' addresses to the address of the clinic or nearby post office box. The health care clinic office manager had access to

the payments made by the health insurance companies and would keep a percentage of the funds paid for claims submitted under the names of the recruited doctors.

In November 2022, the health care clinic office manager was convicted of one count of conspiracy to commit health care fraud, as charged, and sentenced to 12 months of probation and a special assessment fee of $100 and ordered by the court to pay restitution in the amount of $1,250,601, jointly and severally with codefendants.

Pursuant to 5 U.S.C. § 8902a(b)(1), OPM is required to debar any provider that has been convicted, under Federal or State law, of a criminal offense relating to fraud, corruption, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care service or supply.

The acts that led up to the health care clinic office manager's conviction were related to the delivery of health care services and/or supplies. Therefore, her debarment was required based on her November 2022 conviction. Her debarment took effect on March 29, 2023, and will run for a minimum mandatory period of 3 years.

This case was identified by the ASG.

California Pharmacist's Suspension Converted into an Indefinite Debarment

Our office converted the OPM suspension of a California pharmacist into a mandatory debarment based on her exclusion by HHS.

In December 2020, our office suspended a California pharmacist based on her June 2018 indictment filed in the U.S. District Court for the Southern District of California.

In August 2022, the pharmacist was convicted of one count of health care fraud, in violation of 18 U.S.C § 1347, as charged in the indictment. She was sentenced to 1 day of imprisonment, including time served, followed by 3 years of supervised release, and subject to 12 months of home detention. She was also ordered by the court to pay restitution in the amount of $7,693,701 jointly and severally with co-defendants.

According to the indictment, from approximately March 2015 through approximately December 2016, the pharmacist and codefendants caused compounded medication prescription forms to be prepared and distributed to marketers that identified multiple compounded medications formulations. These formulations were purportedly for pain, stretch marks, migraines, the rinsing of wounds, and general wellness. These applications were included on the forms and selected by the marketers because these uses provided the maximum possible health care insurance company reimbursements – rather than being selected based on individual patient needs or medical necessity.

These forms were used to designate prescriptions for each health care beneficiary that marketers and sub-marketers, none of whom had any health care training, selected as appropriate. The marketers selected the prescriptions to maximize health care insurance company reimbursements and, in turn, the kickback amounts that the marketers would receive under their agreements with the pharmacy. The marketers then would send patient and health insurance company information, along with the completed prescription forms, to others involved in the health care scheme for authorization. The marketers also paid or caused physicians to be paid a fee per patient for authorizing the prescriptions. The marketers then caused the authorized prescriptions to be sent to health care insurance companies for fulfillment.

The pharmacist and codefendants conducted little, if any, due diligence upon receipt of the prescriptions to verify whether the beneficiaries actually sought the prescribed medications and in some cases deliberately did not call beneficiaries in order to avoid giving notice to the beneficiaries that the prescriptions were being filled. The prescribed medications had little, if any, medical value or were vitamins for "metabolic general wellness." The compounded formulations were virtually identical for all of the beneficiaries regardless of their purported illnesses, and none of the prescriptions were specifically formulated based on the individualized needs, medical history, allergic reaction potential, contraindications, or conflicts with other prescription medications that were unique to each beneficiary.

Our office was notified that the suspended pharmacist was excluded by the HHS OIG on February 20, 2023. Pursuant to 5 U.S.C. § 8902a(b)(5) and Title 5 Code of Federal Regulations § 890.1004(b), OPM is required to debar any health care provider who has been excluded by another Federal agency. Accordingly, OPM converted the provider's temporary suspension into a mandatory debarment that went into effect on March 30, 2023. The term of her debarment runs for an indefinite period, concurrent with the terms of her exclusion by the HHS OIG.

This case was identified jointly by the OPM OIG Office of Investigations, OPM OIG ASG, and HHS.

Two Podiatry Offices Debarred Based on Ownership by a Debarred Provider

In April 1997, our office debarred a podiatrist based on his exclusion by the HHS OIG. Our debarment and his HHS OIG exclusion remain in effect.

In March 2022, the National Association of Letter Carriers notified our office that they received claims for services rendered by the debarred provider. As a result, in March 2022, we issued a notice to the provider, reminding him of his OPM debarment, which prohibits him from participating in FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans.

We informed the debarred provider that his actions were violations of his debarment terms, and should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the Federal false claims statutes and potentially result in prosecution by the Department of Justice. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEBHP.

The provider's violations prompted ASG to investigate the entities with which the debarred provider was affiliated. The investigation identified two podiatry offices that were owned by the debarred provider. Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that is owned or controlled by a sanctioned provider. As a result, we debarred the two offices effective March 29, 2023. The debarments of the podiatry offices will coincide with the debarment terms of the podiatrist.

This case regarding the two podiatry offices was identified by the ASG.

Evaluations Activities

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

One evaluation was completed during this reporting period.

Evaluation of Merit System Accountability and Compliance Office
Washington, D.C.
Report Number 2021-OEI-001
December 12, 2022

We completed an evaluation of the Merit System Accountability and Compliance Office. We determined that Agency Compliance and Evaluation (ACE) staff generally complied with its Evaluator Handbook and Federal agencies were submitting their independent audit program reports containing the analysis, results, and their corrective actions. ACE staff used those reports during their planning process and the agency's evaluations.

We also found that ACE had formally documented its processes and procedures in multiple documents: its Evaluator Handbook, OPM's Delegated Examining Operations Handbook, its Annual Work Plan Standard Operating Procedures, and its Writing Style and Correspondence Guide. However, ACE did not have its quality control measures and processes for its evaluations formally documented in any of these documents. During our evaluation, an ACE official explained the quality control measures and process. By not documenting its quality control measures and process, ACE management could not be reasonably assured that quality control measures were understood and consistently executed by employees.

We made one recommendation to formalize ACE's internal quality control measures and process for its evaluations work. ACE's management concurred with our finding and implemented corrective actions to address our concerns. Based on our analysis of the corrective actions taken, we consider the recommendation closed.

Legal and Legislative Activities

Under the Inspector General Act of 1978, as amended (5 U.S.C. Ch. 4), OIGs are required to obtain legal advice from a counsel reporting directly to an Inspector General (IG). This reporting relationship ensures that the OIG receives independent and objective legal advice. The OPM OIG Office of Legal and Legislative Affairs discharges this statutory responsibility in several ways, including by providing advice to the Immediate Office of the Inspector General and the OIG office components on a variety of legal issues, tracking and commenting on legislative matters affecting the work of the OIG, and advancing legislative proposals which address waste, fraud, and abuse against and within OPM.

Over the course of this reporting period, the OIG's Office of Legal and Legislative Affairs advised the Inspector General and other OIG components on many legal and regulatory matters. The Office evaluated proposed legislation related to OPM and the OIG's programs and operations. We also tracked and provided comments on proposed and draft legislation to both Congress and the CIGIE Legislation Committee. This reporting period, the OPM IG also took on the new responsibility of serving as Vice-Chair of the CIGIE Legislation Committee.

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

As addressed in the last two semiannual reports to Congress, the newly enacted Postal Service Reform Act of 2022 will impact OPM OIG operations and oversight activities. During this reporting cycle, we met with authorizing committees in the House of Representatives and the Senate to discuss the risks associated with the FEHBP's continued exclusion from the Federal Anti-Kickback Statute. As OPM works to establish the PSHBP within the FEHBP, we remain concerned that Federal funds are at risk from fraud, specifically kickbacks. As we have identified in many semiannual reports to Congress, the FEHBP is specifically excluded from the Anti-Kickback Statute. This exclusion results in an estimated annual loss of tens of millions of dollars to the FEHBP Trust Fund. This exclusion also impedes the OIG's ability to detect, investigate, and obtain restitution regarding kickbacks that occur within the FEHBP. With the establishment of the PSHBP within the FEHBP, a new health benefits program is also vulnerable to fraud with no ability for the OIG to investigate and hold willful, and often brazen, fraudsters accountable. The OPM OIG urges Congress to protect the FEHBP, the PSHBP, and the enrollees of both programs by amending the Anti-Kickback Statute to define the FEHBP as a Federal health care program.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries:

Indictments and Criminal Informations	11
Arrests	3
Convictions	8
Criminal Complaints/Pre-Trial Diversion	1
Subjects Presented for Prosecution	26
Federal Venue	26
Criminal	15
Civil	11
State Venue	0
Local Venue	0
Expected Recovery Amount to OPM Programs	$2,493,632
Civil Judgements and Settlements	$2,301,873
Criminal Judgements and Restitution	$15,236
Administrative Recoveries	$176,523
Expected Recovery Amount for All Programs and Victims[4]	$79,079,838

Investigative Administrative Actions:

FY 2023 Investigative Reports Issued[5]	115
Issued between October 1, 2022, and March 31, 2023	115
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	1
Personnel Suspensions, Terminations, or Resignations	0
Referral to the OPM OIG Office of Audits	0
Referral to an OPM Program Office	3

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued	530
FEHBP Provider Debarment and Suspension Inquiries	1,367
FEHBP Debarments and Suspensions in Effect at the End of the Reporting Period	38,445

4 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.

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

Table of Enforcement Activities

Cases Opened	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations[6]	26	11	0	0	37
Preliminary Investigations[7]	59	12	0	3	74
FEHBP Carrier Notifications/ Program Office	845	8	0	2	855
Complaints – All Other Sources/Proactive[8]	167	5	0	7	179

Cases Closed	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	37	15	0	1	53
Preliminary Investigations	19	2	0	2	23
FEHBP Carrier Notifications/ Program Office	687	6	0	1	694
Complaints – All Other Sources/Proactive	119	21	0	3	143

Cases In-Progress[9]	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	114	31	0	3	148
Preliminary Investigations	46	3	0	1	50
FEHBP Carrier Notifications/ Program Office	279	9	0	0	288
Complaints – All Other Sources/Proactive	22	1	0	1	24

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

OIG Hotline Complaint Activity

OIG Hotline Complaints Received	1,951
Sources of OIG Hotline Cases Received	
Website	960
Telephone	812
Letter	93
Email	83
In-Person	3
OPM Program Office	
Healthcare and Insurance	**272**
Customer Service	103
Healthcare Fraud, Waste, and Abuse Complaint	115
Other Healthcare and Insurance Issues	54
Retirement Services	**903**
Customer Service	712
Retirement Services Program Fraud, Waste, and Abuse	68
Other Retirement Services Issues	123
Other OPM Program Offices/Internal Matters	**43**
Customer Service	35
Other OPM Program/Internal Issues	6
Employee or Contractor Misconduct	2
External Agency Issue (unrelated to OPM)	**733**
OIG Hotline Complaints Reviewed and Closed[10]	1,404
Outcome of OIG Hotline Complaints Closed	
Referred to External Agency	**73**
Referred to OPM Program Office	**632**
Retirement Services	534
Healthcare and Insurance	80
Other OPM Programs/Internal Matters	18
Referred to FEHBP Carrier	**41**
No Further Action	**657**
Converted to a Case	**1**
OIG Hotline Complaints Pending[11]	690
By OPM Program Office	
Healthcare and Insurance	113
Retirement Services	286
Other OPM Program Offices/Internal Matters	3
External Agency Issue (unrelated to OPM)	52
To be determined	236

10 Includes hotline cases that may have been received in a previous reporting period.
11 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, 2022 to March 31, 2023

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	6	$17,094,408
B.	Reports issued during the reporting period with questioned costs	7	$23,644,331
	Subtotals (A+B)	13	$40,738,739
C.	Reports for which a management decision was made during the reporting period:	4	$5,376,539
	1. Net disallowed costs	N/A	$4,725,174
	Disallowed costs during the reporting period	N/A	$4,725,420[1]
	Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$246[2]
	2. Net allowed costs	N/A	$651,365
	Allowed costs during the reporting period	N/A	$651,119[3]
	Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$246[2]
D.	Reports for which no management decision has been made by the end of the reporting period	9	$35,362,200
E.	Reports for which no management decision has been made within 6 months of issuance	4	$15,432,697

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

Appendix I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

October 1, 2022 to March 31, 2023

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	1	$164,212
B.	Reports issued during the reporting period with questioned costs	0	$0
	Subtotals (A+B)	1	$164,212
C.	Reports for which a management decision was made during the reporting period:	0	$0
	1. Net disallowed costs	N/A	$0
	2. Net allowed costs	N/A	$0
D.	Reports for which no management decision has been made by the end of the reporting period	1	$164,212
E.	Reports for which no management decision has been made within 6 months of issuance	1	$164,212

Appendix II

Resolution of Questioned Costs in Final Reports for Insurance Programs

October 1, 2022 to March 31, 2023

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$17,094,408
B.	Value of new audit recommendations issued during the reporting period	$23,644,331
	Subtotals (A+B)	$40,738,739
C.	Amounts recovered during the reporting period	$4,725,174
D.	Amounts allowed during the reporting period	$651,365
E.	Other adjustments	$0
	Subtotals (C+D+E)	$5,376,539
F.	Value of open recommendations at the end of the reporting period	$35,362,200

Appendix III

Final Reports Issued With Recommendations for Better Use of Funds

October 1, 2022 to March 31, 2023

Subject		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	2	$114,354,689
B.	Reports issued during the reporting period with questioned better use of funds amounts	0	$0
	Subtotals (A+B)	2	$114,354,689
C.	Reports for which a management decision was made during the reporting period:	1	$108,213,934
D.	Reports for which no management decision has been made by the end of the reporting period	1	$6,140,755
E.	Reports for which no management decision has been made within 6 months of issuance	1	$6,140,755

Appendix IV

Insurance Audit Reports Issued

October 1, 2022 to March 31, 2023

Report Number	Subject	Date Issued	Questioned Costs
2022-SAG-0025	Blue Cross Blue Shield Association's Service Benefit Plan's Specialty Drug Pharmacy Program as Administered by Prime Therapeutics, LLC for Contract Years 2018 through 2021 in Washington, D.C.	October 27, 2022	$0
2022-ERAG-0011	Premera Blue Cross in Mountlake Terrace, Washington	December 12, 2022	$3,508,556
2022-CRAG-005	GlobalHealth, Inc. in Oklahoma City, Oklahoma	December 13, 2022	$0
2022-ERAG-0012	Cash Management Activities and Aging Refunds for a Sample of Blue Cross and/or BlueShield Plans in Washington, D.C.	December 13, 2022	$635,783
2022-CRAG-008	Humana Health Plan, Inc. in Louisville, Kentucky	December 19, 2022	$347,844
2022-CRAG-004	MercyCare Health Plans in Janesville, Wisconsin	February 2, 2023	$108,102
2022-CAAG-009	Claims Processing and Payment Operations at Premera Blue Cross in Mountlake Terrace, Washington	February 8, 2023	$2,009,414
2022-CRAG-0010	The Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc. in Las Vegas, Nevada	February 15, 2023	$0
1H-08-00-21-015	Group Health Incorporated's Federal Employees Health Benefits Program Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2015 through 2019 in St. Louis, Missouri	February 16, 2023	$15,086,271
2022-CAAG-028	Claims Processing and Payment Operations at Blue Cross Blue Shield of Arizona for Contract Years 2019 through 2021 in Phoenix, Arizona	February 16, 2023	$0
2022-CAAG-023	Claims Processing and Payment Operations at Blue Cross and Blue Shield of North Carolina for Contract Years 2018 through 2020 in Durham, North Carolina	March 3, 2023	$1,948,361
TOTAL			$23,644,331

Appendix V

Internal Audit Reports Issued

October 1, 2022 to March 31, 2023

Report Number	Subject	Date Issued
2022-IAG-003	The U.S. Office of Personnel Management's Fiscal Year 2022 Consolidated Financial Statements in Washington, D.C.	November 14, 2022

Appendix VI

Information Systems Audit Reports Issued

October 1, 2022 to March 31, 2023

Report Number	Subject	Date Issued
2022-ISAG-0017	Federal Information Security Modernization Act Audit - Fiscal Year 2022 in Washington, D.C.	November 15, 2022
2022-ISAG-0020	Information Systems General and Application Controls at Blue Cross Blue Shield of Kansas in Topeka, Kansas	December 14, 2022
2022-ISAG-0024	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland	February 27, 2023
2022-ISAG-0027	Information Systems General and Application Controls at HealthPartners in Bloomington, Minnesota	March 20, 2023

Appendix VII

Evaluation Reports Issued

October 1, 2022 to March 31, 2023

Report Number	Subject	Date Issued
2021-OEI-001	Evaluation of the Merit System Accountability and Compliance Office in Washington, D.C.	December 12, 2022

Appendix VIII

Data Briefs Issued

October 1, 2022 to March 31, 2023

Report Number	Subject	Date Issued
2022-CAAG-0014	Evaluation of COVID-19's Impact on FEHBP Telehealth Services and Utilization in Washington, D.C.	March 6, 2023

Appendix IX

Summary of Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2023

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CI-00-08-022	Federal Information Security Management Act for Fiscal Year 2008 in Washington, D.C.	September 23, 2008	1	0	19
4A-CF-00-08-025	The U.S. Office of Personnel Management's Fiscal Year 2008 Consolidated Financial Statements in Washington, D.C.	November 14, 2008	1	0	6
4A-CI-00-09-031	Federal Information Security Management Act for Fiscal Year 2009 in Washington, D.C.	November 5, 2009	1	0	30
4A-CF-00-09-037	The U.S. Office of Personnel Management's Fiscal Year 2009 Consolidated Financial Statements in Washington, D.C.	November 13, 2009	1	0	5
4A-CF-00-10-015	The U.S. Office of Personnel Management's Fiscal Year 2010 Consolidated Financial Statements in Washington, D.C.	November 10, 2010	3	0	7
4A-CI-00-10-019	Federal Information Security Management Act for Fiscal Year 2010 in Washington, D.C.	November 10, 2010	1	0	41
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.	September 14, 2011	2	0	14
4A-CI-00-11-009	Federal Information Security Management Act for Fiscal Year 2011 in Washington, D.C.	November 9, 2011	1	0	29
4A-CF-00-11-050	The U.S. Office of Personnel Management's Fiscal Year 2011 Consolidated Financial Statements in Washington, D.C.	November 14, 2011	1	0	7
4A-CI-00-12-016	Federal Information Security Management Act for Fiscal Year 2012 in Washington, D.C.	November 5, 2012	1	0	18

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CF-00-12-039	The U.S. Office of Personnel Management's Fiscal Year 2012 Consolidated Financial Statements in Washington, D.C.	November 15, 2012	1	0	3
4A-CI-00-13-021	Federal Information Security Management Act for Fiscal Year 2013 in Washington, D.C.	November 21, 2013	1	0	16
4A-CF-00-13-034	The U.S. Office of Personnel Management's Fiscal Year 2013 Consolidated Financial Statements in Washington, D.C.	December 13, 2013	1	0	1
4A-CF-00-14-039	The U.S. Office of Personnel Management's Fiscal Year 2014 Consolidated Financial Statements in Washington, D.C.	November 10, 2014	3	0	4
4A-CI-00-14-016	Federal Information Security Management Act for Fiscal Year 2014 in Washington, D.C.	November 12, 2014	3	0	29
4K-RS-00-14-076	The Review of the U.S. Office of Personnel Management's Compliance with the Freedom of Information Act in Washington, D.C.	March 23, 2015	0	2	3
4A-RI-00-15-019	Information Technology Security Controls of the U.S. Office of Personnel Management's Annuitant Health Benefits Open Season System in Washington, D.C.	July 29, 2015	1	0	7
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	3	0	27
4A-CF-00-15-027	The U.S. Office of Personnel Management's Fiscal Year 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015	4	0	5
4A-CA-00-15-041	The U.S. Office of Personnel Management's Office of Procurement Operations' Contract Management Process in Washington, D.C.	July 8, 2016	3	0	6
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.	October 13, 2016	2	0	4
4A-CI-00-16-039	Federal Information Security Modernization Act for Fiscal Year 2016 in Washington, D.C.	November 9, 2016	4	0	26

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CF-00-16-030	The U.S. Office of Personnel Management's Fiscal Year 2016 Consolidated Financial Statements in Washington, D.C.	November 14, 2016	12	0	19
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	3	0	4
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York	June 30, 2017	0	1	15
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	7	0	8
4A-CI-00-17-020	Federal Information Security Modernization Act Audit Fiscal Year 2017 in Washington, D.C.	October 27, 2017	8	0	39
4A-CF-00-17-028	The U.S. Office of Personnel Management's Fiscal Year 2017 Consolidated Financial Statements in Washington, D.C.	November 13, 2017	13	0	18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	15	0	21
L-2018-1	Management Advisory Report - Review of the U.S. Office of Personnel Management's Non-Public Decision to Prospectively and Retroactively Re-Apportion Annuity Supplements in Washington, D.C.	February 5, 2018	3	0	3
4A-CI-00-18-022	Management Advisory Report - The U.S. Office of Personnel Management's Fiscal Year 2017 IT Modernization Expenditure Plan in Washington, D.C.	February 15, 2018	1	0	4
4A-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	5	0	5
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1	0	2

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018	2	0	4
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	13	0	52
4A-CF-00-18-024	The U.S. Office of Personnel Management's Fiscal Year 2018 Consolidated Financial Statements in Washington, D.C.	November 15, 2018	15	0	23
4K-CI-00-18-009	The U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, D.C.	December 21, 2018	1	0	3
1C-8W-00-18-036	Information Systems General Controls at University of Pittsburgh Medical Center Health Plan in Pittsburgh, Pennsylvania	March 1, 2019	0	1	5
1C-LE-00-18-034	Information Systems General Controls at Priority Health Plan in Grand Rapids, Michigan	March 5, 2019	0	1	10
4A-CI-00-18-037	The U.S. Office of Personnel Management's Compliance with the Federal Information Technology Acquisition Reform Act in Washington, D.C.	April 25, 2019	4	0	5
4A-CF-00-19-012	The U.S. Office of Personnel Management's Fiscal Year 2018 Improper Payments Reporting in Washington, D.C.	June 3, 2019	1	0	4
4K-ES-00-18-041	Evaluation of the U.S. Office of Personnel Management's Employee Services' Senior Executive Service and Performance Management Office in Washington, D.C.	July 1, 2019	4	0	6
4A-CF-00-19-026	Information Technology Security Controls of the U.S. Office of Personnel Management's Consolidated Business Information System in Washington, D.C.	October 3, 2019	1	0	7

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CI-00-19-008	The U.S. Office of Personnel Management's Compliance with the Data Center Optimization Initiative in Washington, D.C.	October 23, 2019	8	0	23
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	14	0	47
4A-CF-00-19-022	The U.S. Office of Personnel Management's Fiscal Year 2019 Consolidated Financial Statements in Washington, D.C.	November 18, 2019	16	0	20
4K-ES-00-19-032	Evaluation of the Presidential Rank Awards Program in Washington, D.C.	January 17, 2020	4	0	4
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	February 27, 2020 Reissued March 31, 2020	2	0	2
4A-RS-00-18-035	The U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	4	8	12
4A-CF-00-20-014	The U.S. Office of Personnel Management's Fiscal Year 2019 Improper Payments Reporting in Washington, D.C.	May 14, 2020	1	0	3
4A-CI-00-20-007	Information Technology Security Controls of the U.S. Office of Personnel Management's Electronic Official Personnel Folder System Report in Washington, D.C.	June 30, 2020	1	0	3
1H-07-00-19-017	CareFirst Blue Choice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	3	0	8

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-DO-00-20-041	Management Advisory Report - Delegation of Authority to Operate and Maintain the Theodore Roosevelt Federal Building and the Federal Executive Institute in Washington, D.C.	August 5, 2020	2	0	4
4A-CI-00-20-009	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020	8	0	11
4A-HI-00-19-007	The U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, D.C.	October 30, 2020	6	1	24
4A-RS-00-19-038	The U.S. Office of Personnel Management's Retirement Services Disability Process in Washington, D.C.	October 30, 2020	0	5	8
4A-CI-00-20-008	Information Technology Security Controls of the U.S. Office of Personnel Management's Agency Common Controls in Washington, D.C.	October 30, 2020	3	0	4
4A-CI-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020	15	0	45
4A-CF-00-20-024	The U.S. Office of Personnel Management's Fiscal Year 2020 Consolidated Financial Statements in Washington, D.C.	November 13, 2020	16	0	21
1C-A8-00-20-019	Information Systems General Controls at Scott and White Health Plan in Dallas, Texas	December 14, 2020	0	2	12
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021	0	1	2
4A-HI-00-18-026	Management Advisory Report - FEHBP Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C.	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021	1	0	4

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
1C-8W-00-20-017	UPMC Health Plan, Inc. in Pittsburgh, Pennsylvania	June 28, 2021	4	0	17
1H-99-00-20-016	Reasonableness of Selected FEHBP Carriers' Pharmacy Benefit Contracts in Washington, D.C.	July 29, 2021	3	0	3
4A-CI-00-20-034	The U.S. Office of Personnel Management's Office of the Chief Information Officer's Revolving Fund Programs in Washington, D.C.	September 9, 2021 Reissued November 22, 2021	1	0	4
1C-SF-00-21-005	Information Systems General and Application Controls at SelectHealth in Murray, Utah	September 13, 2021	0	2	12
4A-ES-00-21-020	Information Technology Security Controls of the U.S. Office of Personnel Management's Executive Schedule C System in Washington, D.C.	September 30, 2021	1	0	14
4A-CI-00-21-012	Federal Information Security Modernization Act Audit Fiscal Year 2021 in Washington, D.C.	October 27, 2021	19	0	36
4A-CF-00-20-044	The U.S. Office of Personnel Management's Data Submission and Compliance with the Digital Accountability and Transparency Act of 2014 in Washington, D.C.	November 8, 2021	0	1	3
4A-CF-00-21-027	The U.S. Office of Personnel Management's Fiscal Year 2021 Consolidated Financial Statements in Washington, D.C.	November 12, 2021	15	0	20
1C-QA-00-21-003	Independent Health Association, Inc. in Buffalo, New York	January 7, 2022	2	0	33
4A-CF-00-20-029	The U.S. Office of Personnel Management's Utilization of the Improper Payments Do Not Pay Initiative in Washington, D.C.	February 14, 2022	1	1	7
1A-10-17-21-018	Health Care Service Corporation for Contract Years 2018 through 2020 in Chicago, Illinois	February 23, 2022 Reissued March 16, 2022	4	0	18
1D-80-00-21-025	Information Systems General and Application Controls at EmblemHealth in New York, New York	March 21, 2022	0	2	5

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
N/A	Review of the 2017 Presidential Management Fellows Program Application Process Redesign in Washington, D.C.	May 18, 2022	8	0	8
2022-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	June 23, 2022	2	0	6
1B-45-00-21-034	Claims Processing and Payment Operations at the Mail Handlers Benefit Plan for Contract Years 2019 and 2020 in El Paso, Texas	August 16, 2022	3	0	4
1C-59-00-20-043	Kaiser Foundation Health Plan, Inc. in Oakland, California	August 16, 2022	1	0	16
2022-ISAG-006	Information Systems General and Application Controls at Blue Cross Blue Shield of Alabama in Birmingham, Alabama	August 22, 2022	0	1	2
1A-10-15-21-023	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	August 25, 2022	2	0	11
2022-SAG-007	2018 and 2019 Combined Federal Campaigns in Madison, Wisconsin	September 7, 2022	1	0	2
1G-LT-00-21-013	Federal Long Term Care Insurance Program for Contract Years 2017 through 2019 in Portsmouth, New Hampshire	September 12, 2022	2	0	3
	TOTAL		332	29	1056

[1] As defined in OMB Circular No. A-50, resolved means that the audit organization and agency management agree on action to be taken on reported findings and recommendations; however, corrective action has not yet been implemented. Outstanding and unimplemented (open) recommendations listed in this appendix that have not yet been resolved are not in compliance with the OMB Circular No. A-50 requirement that recommendations be resolved within 6 months after the issuance of a final report.

Appendix X

Most Recent Peer Review Results

As of March 31, 2023

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

Subject	Date of Report	Result
System Review Report on the U.S. Office of Personnel Management Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, Tennessee Valley Authority)*	July 8, 2021	Pass[1]
System Review Report on the National Railroad Passenger Corporation Office of Inspector General Audit Organization *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	December 16, 2021	Pass
External Quality Assessment Review of the Office of the Inspector General for the U.S. Office of Personnel Management Investigative Operations *(Issued by the Tennessee Valley Authority Office of the Inspector General)*	January 19, 2023	Compliant[2]
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Special Inspector General for Afghanistan Reconstruction *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	March 10, 2020	Compliant
External Peer Review Report on the Office of Evaluations of the Office of the Inspector General for the U.S. Office of Personnel Management *(Issued by the U.S. General Services Administration Office of Inspector General)*	June 30, 2022	Compliant[3]
External Peer Review Report on the Office of the Inspector General for the Library of Congress *(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)*	July 22, 2021	Compliant

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

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

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

Appendix XI

Investigative Recoveries

October 1, 2022 to March 31, 2023

Statistic Type	Program Office	Type of Recovery	Total Recovery Amount	Total OPM Net
Administrative			**$266,830**	**$176,523**
	Healthcare & Insurance		**$35,065**	**$35,065**
		Voluntary Repayment	$35,065	$35,065
	Retirement Services		**$231,765**	**$141,458**
		Administrative Debt Recoveries	$168,668	$78,361
		Bank Reclamation	$63,097	$63,097
Civil			**$77,461,420**	**$2,301,873**
	Healthcare & Insurance		**$77,461,420**	**$2,301,873**
		Civil Actions	$77,461,420	$2,301,873
Criminal			**$1,351,588**	**$15,236**
	Healthcare & Insurance		**$1,250,602**	**$0**
		Court Assessments/Fees	$0	$0
		Criminal Judgments/ Restitution	$1,250,602	$0
	Retirement Services		**$100,986**	**$15,236**
		Criminal Judgments/ Restitution	$100,986	$15,236
Grand Total			**$79,079,838**	**$2,493,632**

Index of Reporting Requirements

(*Inspector General Act of 1978, As Amended*[1])

Requirement		Page
1	Review of legislation and regulations	41
2	Significant problems, abuses, and deficiencies as well as the associated reports and recommendations for corrective action	6-25
3	Recommendations made before the reporting period, for which corrective action has not been completed	OIG's Website
4	Significant investigations closed during the reporting period	42-44
5	Number of convictions closed during the reporting period resulting from investigations	42–44
6	Audit, inspection and evaluation reports issued during the reporting period, including information regarding the value of questioned costs and recommendations for funds put to better use	47–53
7	Management decisions made during the reporting period with respect to audits, inspections, and evaluations issued during a previous reporting period	49
8	Reportable information under section 804(b) of the Federal Financial Management Improvement Act of 1996	21–22
9	Information pertaining to peer review by other OIGs	70–71
10	Statistical tables showing the number of: investigative reports issued, persons referred for criminal prosecution, and indictments and criminal informations during the reporting period	42–46; 72
11	Metrics used for developing the data for the table showing investigative reports, persons referred for criminal prosecution, and indictments and criminal informations	42–46
12	Reports on investigations involving substantiated misconduct by senior government employees or officials	No Activity
13	Descriptions of whistleblower retaliation, including implicated individuals and any consequences imposed	No Activity
14	Agency attempts to interfere with OIG independence	No Activity
15	Closed investigations, audits, and evaluations not disclosed to the public	42-46
16	Closed investigations involving senior government employees, not disclosed to the public	No Activity

[1] See James M. Inhofe National Defense Authorization Act for Fiscal Year 2023, H.R. 776-1200, 117th Cong. § 5273.

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

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