Office of the Inspector General

SEMIANNUAL REPORT TO CONGRESS

April 1, 2023 – September 30, 2023

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Productivity Indicators

Financial Impact

Audit Recommendations for Recovery of Funds	Management Commitments to Recover Funds	Recoveries Through Investigative Actions
$31,025,335	$15,953,752	$3,164,270

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
18	0	0	0	74	6
6	7	1789	2354	405	1316
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 April 1, 2023, and September 30, 2023, as part of our mission to provide independent, transparent, and objective oversight of OPM programs and operations.

The OPM OIG continues to make progress in working with OPM to close open recommendations from the OIG. I reported in our last Semiannual Report that we launched a new initiative to identify three priority open recommendations. Since that time, two of the three original priority open recommendations have been closed. Those recommendations addressed strengthening information security and strengthening internal controls used in administering common services. We appreciate OPM's attention to these and other open recommendations, but action is still needed to address the hundreds of remaining open recommendations.

One of our priority areas for oversight is OPM's implementation of 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 imperative to prevent fraud and improper payments before they happen. We have a team of auditors engaged in ongoing reviews and a cross-cutting team of OIG staff maintains regular communication with the agency about implementation efforts.

Early collaboration is important between the agency and the OIG as the PSHBP is being designed and implemented. A December 3, 2021, memorandum from the Office of Management and Budget emphasized the importance of proactive and transparent collaboration for new programs or for programs that undergo significant changes. The OIG initiated for the first time the practice of holding "Gold Standard" meetings that include agency and OIG leadership. The purpose of these meetings is to foster timely communication, address issues as they arise, and promote collaboration as well as cooperation with OIG requests.

The OIG has a pressing need for additional resources in order to fully carry out the proactive oversight needed. The OIG has not, to date, received resources specifically for PSHBP oversight. Independent oversight is needed to protect taxpayer dollars and the integrity of the PSHBP.

The OIG released 18 final audit reports during the reporting period, which represent oversight of both OPM and FEHBP health plans. Our audits from this reporting period disclosed a range of significant findings. For example, an audit of FEHBP claims by Blue Cross and Blue Shield plans processed in accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 identified FEHBP overpayments of over $22 million. A performance audit of one of OPM's major IT systems identified several areas in need of improvement, such as an outdated and inaccurate system security plan, not consistently performing continuous monitoring of security controls, and vulnerable software in the system's technical environment.

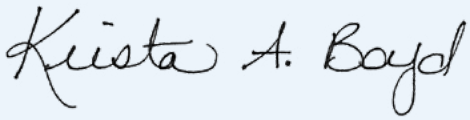
We also investigated a range of fraud, waste, and abuse allegations during the reporting period. Our investigative efforts resulted in the recovery of $3.16 million, six arrests, and seven convictions.

These efforts included investigating what became Department of Justice's first case of a doctor convicted at trial for health care fraud in billing for office visits in connection with patients seeking COVID-19 tests. The case involved a doctor who submitted more than $10 million in false and fraudulent evaluation and management claims to Government health programs and insurers for what were, in fact, drive-through COVID-19 tests. These claims included over $1.5 million paid by FEHBP health insurance carriers.

A years-long case involving a former OPM contracting officer came to a close when the former contracting officer was sentenced. The case involved allegations that the contracting officer steered approximately $10 million in OPM contracts to an IT management and consulting firm cofounded by the contracting officer's spouse.

The OIG issued 405 administrative sanctions of FEHBP health care providers. Our total suspensions and debarments for fiscal year 2023 was 933, the highest level since 2019. These suspensions and debarments help protect FEHBP enrollees and the integrity of the FEHBP. The actions are issued against providers who commit certain violations, such as conviction of a crime.

This report represents the hard work and achievements of the outstanding professionals at the OIG. Beyond the metrics and summaries included in this report, there are many more "behind the scenes" accomplishments by OIG employees who contribute to our collective mission to provide independent and objective oversight of OPM's programs and operations.



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.

Table of Contents

OIG Office Locations

Washington, District of Columbia
Cranberry Township, Pennsylvania
Jacksonville, Florida

Audit Activities

Health Insurance Carrier Audits

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

The Office of the Inspector General (OIG) insurance audit universe encompasses over 200 audit sites consisting of health insurance carriers, sponsors, and underwriting organizations participating in the FEHBP. The number of audit sites fluctuates due to the addition, non-renewal, and merger of participating health insurance carriers. Combined premium payments for the FEHBP total over $61 billion annually. The health insurance carriers audited by the OIG are classified as either community-rated or experience-rated.

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

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

Community-Rated Carriers

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

Premium Rate Review Audits

Our premium rate review audits focus on the rates that are set by the health plan and ultimately charged to the FEHBP subscriber, OPM, and taxpayers. When an audit identifies that 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 are subject to 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 in a model that is filed and approved with the appropriate State regulatory body or used in a consistent manner for all eligible community groups that meet the same criteria as the FEHBP; and
- The 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 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 (SSSG) comparison rating methodology.

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

The FEHBP-specific MLR requires carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must pay a subsidization penalty to OPM.

The following summaries present notable findings in the two audit reports of community-rated FEHBP carriers issued during this reporting period.

Medical Mutual of Ohio
Cleveland, Ohio
Report No. 2022-CRAG-0032
August 21, 2023

We determined that portions of Medical Mutual of Ohio's (the Plan) 2020 FEHBP premium rate development and the 2018 through 2020 MLR filings were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM. As such, the FEHBP is due $67,506 for defective pricing in contract year 2020. In addition, the FEHBP is due lost investment income of $4,423 on the premium overpayments. The reduction in premium rates, as well as additional reporting errors identified, led to an overstated MLR credit of $4,281 in 2018 and understated MLR penalties, totaling $649,974, in contract years 2019 and 2020.

The Plan lacked sufficient controls to consistently administer FEHBP enrollment, benefits, and claims per the terms of its contract with OPM.

Specifically, our audit identified the following:

- The Plan applied incorrect trend factors in its 2020 FEHBP premium rate development;
- The Plan erroneously included multiple plan codes in one FEHBP MLR calculation when they should have been calculated and filed individually, based on OPM's defined coverage areas;
- The MLR filings included duplicate Accountable Care Organization expenses in 2018 and 2019 and inaccurate Patient Centered Outcomes Research Institute expenses in contract years 2018 through 2020;
- The Plan lacked sufficient internal controls, including written policies and procedures, to resolve Centralized Enrollment Clearinghouse System discrepancies within 1 year of the identification of the initial error as required by its contract with OPM;
- The Plan lacked policies and procedures to assess and apply the 31-day extension of coverage for eligible FEHBP dependent members terminating due to reaching the maximum dependent coverage age of 26 and members terminating due to a benefit coverage tier reduction (e.g., a change from family coverage to self-only coverage);
- The Plan had insufficient internal controls over the management of FEHBP enrollment records and the manual processing of claims, resulting in unsupported termination dates and claims processing errors; and
- The Plan lacked written policies and procedures to document its FEHBP-specific policies regarding the application of same-day copayments, which were also not reflected in the FEHBP Benefits Brochure.

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

Health Alliance Plan
Detroit, Michigan
Report No. 2022-CRAG-038
August 15, 2023

We determined that portions of Health Alliance 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. We found that the Plan lacked adequate internal controls over its FEHBP rating process.

The Plan's internal controls related to the FEHBP rate development process were insufficient to meet the terms of its contract with OPM.

Specifically, our audit identified the following:

- The Plan could not provide sufficient source documentation for several of the FEHBP premium rate development components for contract years 2019 through 2021; and
- The Plan erroneously included some claims in its Adjusted Community Rating (ACR) claims data for the 2020 and 2021 FEHBP premium rate developments.

The Plan agreed with the premium rate development finding and disagreed with the claims finding. We maintain that these claims should not have been included in the FEHBP's ACR experience claims data per the guidance provided in OPM's Carrier Letters 2019-07 and 2020-13.

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 four final audit reports on experience-rated health plans (not including information security reports) participating in the FEHBP. The four final audit reports contained recommendations for the return of over $30 million to the OPM-administered health care trust fund.

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 summarized below are representative of our oversight of the BCBS plans.

BlueCross BlueShield of Massachusetts
Boston, Massachusetts
Report No. 2022-ERAG-0013
April 13, 2023

Our audit of the FEHBP operations at BlueCross BlueShield of Massachusetts (BCBS of MA) covered the Plan's administrative expense charges, cash management activities and practices, and fraud and abuse program activities. We questioned $50,667 in unallocable cost center expenses that were charged to the FEHBP and $2,775 for lost investment income on these questioned charges.

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

Except for these questioned cost center charges, we concluded overall that BCBS of MA's administrative expenses charged to the FEHBP were actual, allowable, necessary, and reasonable expenses incurred in accordance with Contract CS 1039 and applicable laws and regulations. We also determined that BCBS of MA handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations concerning cash management in the FEHBP. In addition, we determined that BCBS of MA complied with the communication and reporting requirements for submitting fraud and abuse cases to the OIG.

Blue Shield of California
Oakland, California
Report No. 2022-ERAG-0021
September 26, 2023

Our audit of the FEHBP operations at Blue Shield of California (BS of CA) 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. We questioned $5,517,874 in health benefit charges, net administrative expense overcharges, cash management activities, and lost investment income. Our most significant administrative expense findings were that BS of CA overcharged the FEHBP $2,224,366 for unallowable and unallocable costs from cost centers, natural accounts, and account payable transactions and $2,210,551 for employee compensation costs.

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

The audit disclosed no significant findings pertaining to either (1) BS of CA's cash management activities and practices related to FEHBP funds or (2) BS of CA's fraud and abuse program activities. Overall, we determined that BS of CA handled FEHBP funds in accordance with Contract CS 1039 and applicable laws and regulations concerning cash management in the FEHBP. We also determined that BS of CA complied with the communication and reporting requirements for submitting fraud and abuse cases to the OIG.

Experience-Rated Comprehensive Medical Plans

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

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

Blue Shield of California Access+ HMO
Oakland, California
Report No. 2022-ERAG-0022
August 21, 2023

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

We questioned $2,479,193 in health benefit charges, net administrative expense overcharges, and lost investment income. We also identified a procedural finding regarding the Plan's fraud and abuse program. Our most significant health benefit refund and recovery findings were that the Plan had not returned 1,453 provider offset refunds, totaling $1,374,101, and 26 cash receipt refunds, totaling $549,141, to the FEHBP. Our most significant administrative expense findings were that the Plan overcharged the FEHBP $145,091 for employee compensation costs and charged the FEHBP $119,713 for unallowable and unallocable costs from 3 natural accounts, 8 cost centers, and 47 accounts payable transactions.

The Plan agreed with all the questioned amounts as well as the procedural finding for the Plan's fraud and abuse program. As part of our review, we verified that the Plan subsequently returned $2,269,668 of these questioned costs to the FEHBP. Since the Plan had unreimbursed administrative expenses during the audit scope that covered the remaining questioned amounts of $209,525, no additional amounts are due to the FEHBP for this audit.

Global Audits

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

We issued one final global audit report related to the processing of claims at all BCBS plans in accordance with the Omnibus Budget Reconciliation Acts (OBRAs) of 1990 and 1993. This audit report questioned over $22 million due to manual processor and system errors.

Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021
Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida
Report Number 2022-CAAG-035
June 27, 2023

Our audit of the FEHBP claims processed in accordance with OBRAs 1990 and 1993 at all BCBS plans was performed to determine if the Blue Cross and Blue Shield Association's (Association) internal controls over its claims processing system were sufficient to ensure the proper processing and payment of OBRA claims. For claims subject to OBRA 90 provisions, we identified 447 improperly paid claims resulting in FEHBP overpayments of $22,482,081. Specifically, we identified:

- $14,974,275 in actual and estimated program overcharges that occurred because of software errors;
- $7,069,824 in program net overcharges resulting from a problem with a Centers for Medicare and Medicaid Services file format; and
- $437,982 in program overcharges owing to manual processor and system errors.

For claims subject to OBRA 93 provisions, we identified 10 improperly paid claims resulting in FEHBP overpayments of $374,124. Specifically, we identified:

- $340,079 in program overcharges due to claims with certain procedure code modifiers not being priced under OBRA 93 provisions; and
- $34,045 in program overcharges resulting from manual processor errors.

The final report included seven monetary and four procedural recommendations. The Association agreed with most of the recommendations and is in the process of implementing corrective actions and recovering the identified overpayments. All the recommendations remain open.

Information Systems Audits

OPM manages a wide portfolio of information systems to fulfill its mission. Although the Defense Counterintelligence and Security Agency now administers the background investigations program for the Federal Government, OPM continues to operate the systems that support this program. OPM systems also support the processing of retirement claims and multiple governmentwide human resources services.

Private health insurance carriers participating in the FEHBP rely upon information systems to administer health benefits to millions of current and former Federal employees and their dependents. The ever-increasing frequency and sophistication of cyberattacks on both the private and public sector makes the implementation and maintenance of mature cybersecurity programs a critical need for OPM and its contractors.

Our information technology (IT) audits identify potential weaknesses in the auditee's cybersecurity posture and provide tangible strategies to rectify and/or mitigate those weaknesses. The selection of specific audits to conduct each year is based on a risk assessment model that considers various factors, including the size of the health insurance carrier, the sensitivity of the information in the system, the time elapsed since the last audit, and our previous audit results.

Our audit universe during the reporting period encompassed all 52 OPM-owned information systems as well as the 68 information systems used by private sector entities that contract with OPM to process Federal data. We issued four IT system audit reports during the reporting period. One notable report is summarized below.

Audit of the Information Technology Security Controls of the U.S. Office of Personnel Management's Benefits Plus System
Washington, D.C.
Report Number 2023-ISAG-007
August 9, 2023

Benefits Plus (BP) is one of OPM's major IT systems. We completed a performance audit of BP to ensure that the system's security controls meet the standards established by the Federal Information Security Modernization Act (FISMA), the National Institute of Standards and Technology (NIST), the Federal Information System Controls Audit Manual, and OPM's Office of the Chief Information Officer. We identified several areas in need of improvement. While the system's security categorization was developed in accordance with applicable guidelines, its system security plan was outdated and inaccurate in some cases and included controls from a previous version of NIST's cybersecurity risk framework. In addition, although the system's security and risk assessments were also compliant with standards, continuous monitoring of security controls was not performed consistently. We also identified significant issues with plans of action and milestones, contingency planning, and documentation of how controls were implemented. Perhaps the most significant concern was that we found vulnerable software in the system's technical environment.

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 annual Top Management Challenges report, oversees OPM's annual financial statement audit, and performs risk assessments of OPM programs and operations. Our auditors work with program offices to resolve and close internal audit recommendations.

The three audits summarized below are representative of our work.

OPM's Travel Charge Card Program
Washington, D.C.
Report No. 2022-IAG-0016
April 18, 2023

The Travel and Transportation Reform Act of 1998 (Public Law 105–264) requires Government employees to use the Government travel charge card for travel expenses when on official business. Our auditors completed a performance audit of OPM's Travel Charge Card Program. OPM's Travel Charge Card Program is administered by OPM's Office of the Chief Financial Officer's (OCFO) Business Services and Operations (BSO) group. The OCFO is responsible for issuing internal travel policy guidance and processing procedures. The BSO group serves as the intermediary between the cardholder, the card-issuing bank (Citibank), and OPM. The BSO group is also responsible for administering and managing OPM's Travel Charge Card Program and providing oversight and administration assistance for the Travel Charge Card Program throughout OPM at the agency level.

The objectives of our audit were to determine whether OPM's internal controls for its Travel Charge Card Program were effectively developed and implemented to prevent and detect travel charge card fraud, misuse, and abuse by program participants; ensure OPM's Individually Billed Account (IBA) and Centrally Billed Account (CBA) travel charge card transactions were properly authorized/approved, adequately documented, monitored, reported, and for legitimate business purposes; and determine if all program participants—including cardholders, charge card managers, Agency/Organization Program Coordinators, and Approving Officials—were trained in travel charge card management.

We determined that the OCFO needs to strengthen its internal controls over OPM's Travel Charge Card Program. Our audit identified the following areas requiring improvement. The OCFO:

- Lacks clear, concise, and accurate policies and procedures governing their Travel Charge Card Program;
- Does not track separated employees or card cancellations and does not utilize Citibank's reports to conduct periodic reviews;
- Was unable to provide support to confirm completion of training for 40 IBA cardholders, all 19 CBA cardholders, all 20 Approving Officials, all 22 Agency/Organization Program Coordinators, and the Agency Program Coordinator;

- Did not ensure that all 49 sampled IBA travel charge card transactions, totaling $19,169, and all 16 sampled CBA transactions, totaling $81,176, were approved by the proper officials and adequately documented; and

- Does not have controls in place to prevent IBA travel charge cardholders from withdrawing more cash advances than allowed. We found 117 out of 1,152 cash advances were over the $300-per-transaction limit, accounting for an overage in allowable Automated Teller Machine cash advances of $7,597.

The OCFO concurred with 19 out of 21 of our recommendations, partially agreed with 1, and did not concur with 1.

OPM's Compliance with the Payment Integrity Information Act of 2019
Washington, D.C.
Report No. 2023-IAG-002
May 22, 2023

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

The objective of our audit was to determine whether OPM complied with PIIA for fiscal year (FY) 2022. We determined that OPM is in compliance with PIIA for FY 2022. As shown below, OPM met all 10 PIIA requirements:

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

In addition, there are two outstanding audit findings from prior years' audits. These findings pertain to Retirement Services not meeting its reduction target and not providing documentation to support its contention that further reduction of the target would be cost prohibitive and Retirement Services not meeting the intent of PIIA because its improper payments rates have been virtually stagnant since FY 2013.

OPM's Retirement Services' Settlement Process
Washington, D.C.
Report No. 2022-IAG-0019
June 15, 2023

The Retirement Services program office routinely reviews a selected sample of annuity payments to determine if an overpayment has been made. If Retirement Services determines that an overpayment has been made to an annuitant, the annuity is recalculated, an initial decision is made on the overpayment by Retirement Services' Legal Reconsideration group, and a letter about the debt is sent to the annuitant. The annuitant then has three options: accept OPM's initial decision and repay the debt, set up a repayment plan, or appeal OPM's decision to the Merit Systems Protection Board (MSPB).

Retirement settlements consist of all debt cases in which an annuitant, spouse, child survivor, or their representative has been issued a final decision by OPM on a debt matter and has chosen to appeal that decision to the MSPB. When the annuitant does not agree with OPM's initial decision, the annuitant must complete an MSPB application for reconsideration to appeal the decision. The Appeals group within Retirement Services reviews retirement overpayment cases that have been appealed to the MSPB. After an appeal to the MSPB, the Appeals group tries to reach a settlement agreement with the appellant to collect the overpayment. The settlement agreement includes terms of the collection for the overpayment, is signed by the appellant and a legal administrative specialist during a hearing with an Administrative Judge, and is enforced by the MSPB.

The objectives of our audit were to determine if OPM's Retirement Services office and the OCFO are following their respective policies and procedures for the retirement settlements process and if OPM properly reported retirement settlement overpayments as improper payments on paymentaccuracy.gov and accompanying materials.

We determined that:

1. Retirement Services did not follow its policies and procedures when processing settlement agreements. Specifically, for the 51 settlement agreements processed during our audit scope, we identified:

- Twenty-four settlement agreements with monthly installment agreements over the allowable 98 months;
- Seven settlement agreements for appellants requesting a financial hardship that were missing required credit reports; and
- Three settlement agreements with waivers for more than 20 percent of the overpayment that did not have an explanation or documentation to support why the agreements had been granted waivers over the stated threshold.

2. OPM did not correctly report improper payments. Retirement Services and the OCFO reported a net amount of $203,265 for 11 settlement agreements that included a waiver, rather than the gross amount of $370,225, resulting in $166,960 not reported as improper payments.

3. Retirement Services and the OCFO did not have policies and procedures regarding how improper payments should be reported.

4. OPM wrote off $100,000 of a reemployed annuitant's debt because Retirement Services did not stop the annuity in a timely manner.

Retirement Services concurred with all five recommendations made in our audit report.

Special Audits

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

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

Our office also conducts audits of Pharmacy Benefit Managers, or 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, also known as the 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 one limited-scope audit with findings conducted by the Special Audits Group during this reporting period.

Audit of EmblemHealth Dental's 2024 Premium Rate Proposal for the Federal Employees Dental and Vision Insurance Program
Jacksonville, Florida, and Cranberry Township, Pennsylvania
Report Number 2023-SAG-014
July 28, 2023

We conducted a limited-scope performance audit of EmblemHealth Dental's 2024 premium rate proposal for the FEDVIP. Our audit objective was to determine whether premium rates proposed for calendar year 2024 were in accordance with the terms of the carrier's contract and Federal regulations. The audit also included a review of the carrier's 2022 certified annual accounting statements (AAS) for FEDVIP operations. Audit fieldwork was conducted remotely from our Jacksonville, Florida, and Cranberry Township, Pennsylvania, offices from June to July 2023.

2024 Premium Rate Proposal Review
The results of our audit identified one finding related to overestimated claims and higher-than-needed premium increases in the carrier's 2024 rate proposal. We recommended that three unsupported loadings be removed from within the completion, trend, and enrollment change factors used by the carrier in its rating sheet, thereby limiting the premium increase to meet the consolidated retention guarantee. Final selection and approval of premium rates is OPM's responsibility, and our recommendation is solely based on the best-supported estimates needed to accurately predict the required premium rates at the retention level guaranteed by the carrier.

2022 Annual Accounting Statement Review

The results of our review showed that the carrier had sufficient policies and procedures in place to ensure that its 2022 AAS was accurately reported to OPM. During the verification of the AAS figures, we did find that a comparison of the 2022 Premium Rate Proposal to the 2022 AAS showed that the carrier overestimated its claims for 2022, thereby exceeding its retention guarantee and gaining additional profit. OPM should consider the carrier's history of overestimating its claims each year when negotiating the rates since any shortfall in anticipated claims results in additional profit to the carrier and a potential overcharge to Federal employees.

The results of the audit were discussed with carrier officials at an exit conference on July 21, 2023. We notified the carrier that the memorandum of findings is issued directly to OPM's contracting officer to assist in finalizing the carrier's 2024 premium rates for the FEDVIP.

The carrier overestimated its initial 2024 FEDVIP premium rate proposal.

Enforcement Activities

Investigative Activities

The OPM OIG Office of Investigations' mission is to protect the public, Federal employees, annuitants, and their eligible family members from fraud, waste, abuse, or mismanagement in OPM programs through criminal, civil, and administrative investigations related to OPM programs and operations. Our investigations safeguard the financial and programmatic integrity of 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 their eligible family members receive benefits through these OPM programs, which annually distribute more than $161 billion in benefits.

The Office of Investigations' oversight of OPM programs and operations has three investigative priorities:

- Investigating alleged harm—physical or financial—to Federal employees, annuitants, or their eligible family members involved in OPM programs. Examples include investigating unscrupulous providers harming patients by performing unnecessary procedures, inappropriate opioid prescribing that puts FEHBP members at risk, and identity theft schemes that purloin Federal annuitants' or survivor annuitants' annuities.
- Investigating alleged substantial financial loss to OPM programs. Improper payments and fraud, waste, and abuse squander taxpayer dollars. Our investigative efforts recover millions of dollars annually to be returned to OPM programs.
- Investigating alleged OPM program vulnerabilities or issues that could allow for additional or ongoing fraud, waste, or abuse. These investigations are an essential part of our agency oversight mission and can result in referrals for OPM OIG audits or evaluations to improve program performance or prevent further fraud, waste, or abuse.

In this semiannual report to Congress, we report the recovery of $3.16 million, six arrests, and seven convictions. We highlight a selection of cases representative of our investigative efforts and oversight activities. We also discuss challenges to our oversight efforts. Our investigations during this 6-month reporting period involve a variety of different types of allegations and highlight the breadth of the OPM OIG's investigative work, including a health care fraud investigation of a case with a milestone COVID-19 jury conviction; retirement fraud, waste, and abuse investigations that ended years of post-death annuity payments; and an integrity investigation into a former OPM employee whose actions resulted in millions of dollars in contract fraud.

An indictment is merely an allegation. Defendants referenced in these case summaries who have not pleaded guilty or been convicted are presumed innocent unless and until proven guilty beyond a reasonable doubt in a court of law.

Health Care Fraud, Waste, and Abuse Case Summaries

The majority of investigations conducted by the OPM OIG are investigations of health care fraud, waste, and abuse in the FEHBP. We pursue these matters to protect Federal employees, retirees, and their eligible family members and to detect and prevent improper payments within the FEHBP universe of over 200 health plans collectively insuring more than 8 million lives. Our health care investigations can intercede in physical or financial harm and return hundreds of thousands of dollars through settlements or court-ordered restitution.

Our investigations lead to settlements, fines, and/or imprisonment. Investigations can also result in referrals to the OPM OIG Administrative Sanctions Group, which can exclude unscrupulous medical providers or entities from participation in Federal health care programs. We work in partnership with the U.S. Department of Justice (DOJ), the Federal Bureau of Investigation, and other Federal, State, and local law enforcement agencies to stop harmful fraud, waste, and abuse schemes that affect OPM programs and their members.

The case summaries herein show the scope of the OPM OIG's health care investigations. Some cases in this section, such as *Durable Medical Equipment Providers Indicted in Million-Dollar Health Care Fraud Scheme*, are successful actions against common types of health care fraud. Others are resolutions to unique cases with novel schemes, including one case that specifically involved allegations that a provider's fraudulent actions targeted Federal law enforcement as part of a false claims scheme and another case that is the first doctor convicted at trial by the DOJ for health care fraud in billing for office visits in connection with patients seeking COVID-19 tests.

Case Update: Medical Provider Convicted at Trial for COVID-19 Fraud

In our previous Semiannual Report to Congress (October 1, 2022, through March 31, 2023), we discussed our investigation that led to the indictment of a doctor who submitted false and fraudulent evaluation and management claims for what were, in fact, drive-through COVID-19 tests. That doctor was convicted by a jury in the U.S. District Court for the District of Maryland on August 4, 2023, of five counts of health care fraud. This case, per information from the DOJ, is the first case of a doctor convicted at trial by the DOJ for health care fraud in billing for office visits in connection with patients seeking COVID-19 tests.

This conviction's first-of-its-kind nature is important in proving that the Government can hold accountable health care providers who, for their own financial gain, exploited the dire situations of the COVID-19 pandemic and the need for widespread testing. The doctor in this case submitted more than $15 million in false and fraudulent claims to Government health programs and insurers. FEHBP health insurance carriers had paid $1,461,596 related to the false claims. Many of the patients tested were asymptomatic or receiving tests for employment or travel requirements—and it was therefore unnecessary for the provider to submit evaluation and management claims.

Sentencing is scheduled for November 2023. The doctor faces a maximum sentence of 10 years in Federal prison per conviction on each of the five counts of health care fraud.

Hearing Aid Provider Settles False Claims Allegations Related to Hearing Tests, Protection for Federal Law Enforcement Officers

Based on the proactive efforts by one of our criminal investigators, the OPM OIG opened an investigation into allegations that a hearing aid provider solicited FEHBP members—specifically individuals working in Federal law enforcement—to use custom hearing protection devices that the hearing aid provider claimed were covered under the FEHBP at no cost to FEHBP members. The hearing aid provider claimed that Federal law enforcement officers were eligible to receive custom hearing protection devices. The hearing aid provider submitted claims to FEHBP health insurance carriers for hearing aids and claims associated with sensorineural hearing loss (a condition typically caused by damage to the inner ear) or tinnitus. These claims were submitted regardless of whether a hearing test was completed or the FEHBP member had hearing loss or tinnitus. The FEHBP members were generally not informed that they were diagnosed with hearing loss or tinnitus or that a claim was being submitted for hearing aids.

FEHBP health insurance carriers paid $21,600 in potentially fraudulent claims to the hearing aid provider. On May 26, 2023, the hearing aid provider agreed to a settlement with the Government to resolve the allegations that it submitted false claims. Per the settlement, the hearing aid provider paid $24,000, including $21,600 in restitution to OPM.

Durable Medical Equipment Providers Indicted in Million-Dollar Health Care Fraud Scheme

Three individuals were indicted in the U.S. District Court for the Southern District of Florida for their alleged participation in a massive durable medical equipment and telemedicine scheme. We received information about the allegations from a Federal law enforcement partner, and our investigation found that FEHBP health insurance carriers had paid more than $1.16 million in claims related to the scheme.

The scheme operated through an online portal developed with the intent of connecting durable medical equipment orthotic brace suppliers with marketers who recruited patients. Telemedicine companies paid medical professionals to sign attestations that the durable medical equipment was medically necessary despite there not being a patient relationship or a physical examination. In many cases, patients were never contacted at all.

Further judicial action is expected in this case.

$12.5 Million Settlement Ends Double-Billing Scheme That Financially Harmed FEHBP Members

Based on a complaint from an FEHBP member, we opened an investigation into an urgent care and a hospital allegedly billing for the same services that happened in one visit. When the FEHBP member raised their concerns about the issue with the hospital, they were offered a prepaid credit card for $125, which was equal to the emergency room copay in dispute. Based on FEHBP member interviews, the hospital routinely engaged in this duplicate billing as part of its standard business practice.

Generally, the duplicate billing occurred when FEHBP members visited the urgent care, not the hospital's emergency room. The duplicate claims in this case caused financial harm to FEHBP members who were billed for more expensive copays for emergency room visits that never occurred and FEHBP health insurance carriers receiving unbundled or escalated claims.

FEHBP members suffered financial harm in this case when required to pay expensive copays for emergency room visits that never occurred.

The hospital agreed to pay $12.5 million to resolve the allegations that it committed billing errors that potentially resulted in overpayments for services. As part of that settlement, the FEHBP received $667,901, which included the identified loss as well as investigative costs and lost investment income.

Oncology and Hematology Practice Settles Over Inappropriately Billed Medical Services

We opened an investigation after receiving information from the Civil Division of the U.S. Attorney's Office for the District of Maryland about an oncology and hematology medical practice with suspicious billing practices. Specifically, the practice was identified as an outlier for certain evaluation and management codes, and some providers who traveled internationally had billed medical services on dates they were out of the country.

In all, FEHBP health insurance carriers paid $75,487 to the oncology and hematology practice for questionable claims. On July 19, 2023, the practice agreed to a settlement to resolve the allegations. From the total settlement of $850,949, the FEHBP received $47,949.

According to the settlement agreement, the practice improperly submitted claims for evaluation and management using a code modifier that is only appropriate for separate and distinct evaluation and management services on the day a patient receives a procedure or other service. Some claims were billed under a physician rather than the non-physician provider who treated the patient in the physician's temporary absence.

Durable Medical Equipment Provider Rubber-Stamped Unnecessary Prescriptions as Part of Fraud Scheme

In April 2017, we received information from a Federal law enforcement partner about a Maryland durable medical equipment company that allegedly delivered and billed for durable medical equipment that was not requested by patients or prescribed by physicians.

Our review of claims data found that the durable medical equipment company was paid $305,850 by FEHBP health insurance carriers.

Our investigation found that the owner of the company engaged in illegal kickbacks to secure referrals for the durable medical equipment, which the company then billed to Federal health care programs. These claims were not based on medical necessity. In some incidents, referring physicians submitted claims but never treated or evaluated patients and instead rubber-stamped prescriptions for the unnecessary durable medical equipment.

The multiagency investigative team on this case learned that the owner was also being investigated by the U.S. Attorney's Office for the Central District of California for allegations related to referrals of compounded drug prescriptions. The cases were merged.

In September 2020, the owner pleaded guilty to one count of conspiracy to solicit and receive illegal remunerations for health care referrals. On May 1, 2023, the owner was sentenced to 24 months of probation, 8 months of home detention, and ordered by the court to pay more than $7 million in restitution. The FEHBP received $23,392 of that restitution order.

The FEHBP's Exclusion from Anti-Kickback Statute

The Anti-Kickback Statute makes it illegal for health care providers to knowingly and willfully accept bribes or other remuneration in exchange for business. In the words of former U.S. Department of Health and Human Services (HHS) Inspector General June Gibbs Brown:

> Anti-Kickback Statute is the guarantor of objective medical advice for Federal health care beneficiaries.... [This statute] helps ensure that providers refer patients based on the patients' best medical interests and not because the providers stand to profit from the referral.

Because of what our office believes was a misunderstanding about the nature of the FEHBP, the FEHBP is explicitly excluded from the list of Federal health care programs to which the Anti-Kickback Statute applies. The OPM OIG's ability to successfully resolve some of its health care investigations is impeded by the FEHBP's exclusion from the Anti-Kickback Statute, which constrains our office's ability to protect the FEHBP and its members from improper conduct that is a Federal crime when it involves any other Federally funded health care program.

When U.S. Attorneys' Offices pursue cases based on violations of the Anti-Kickback Statute, the FEHBP is ineligible to receive restitution. In these instances, the program's losses, sometimes in the millions of taxpayer dollars, go unrecovered. In most cases, there is no alternative path to recourse for OPM.

The Anti-Kickback Statute's exclusion will also affect the Postal Service Health Benefits Program (PSHBP) when it begins disbursing benefits in 2025. We continue to work with Congress and our Office of Legal and Legislative Affairs to address this issue. The Office of Investigations considers rectifying the Anti-Kickback Statute exclusion essential to effectively protecting the FEHBP and PSHBP.

The investigations described below were referred to our office during this reporting period and were negatively affected or closed because of the FEHBP's exclusion from the Anti-Kickback Statute.

Investigation into Pharmaceutical Company Closed Because of Anti-Kickback Statute Exclusion

We received information in May 2022 from the U.S. Attorney's Office for the Eastern District of Pennsylvania about a pharmaceutical company alleged to be providing improper pre-authorizations for a medication. The medication at issue could cost more than $15,000 for a 30-day supply. The FEHBP paid more than $28.7 million in claims for the medication between 2015 and 2022. The investigative team, including OPM OIG agents, interviewed more than 30 FEHBP members about the allegations to determine if the pharmaceutical company's actions were appropriate.

The FEHBP paid more than $28.7 million to the pharmaceutical company, but because the investigation was pursued under the Anti-Kickback Statute, we were unable to recover any of those taxpayer dollars.

In June 2023, the prosecution strategy for the U.S. Attorney's Office changed and it was determined that the case would be pursued as violations of the Anti-Kickback Statute. Because the FEHBP is excluded from the Anti-Kickback Statute, we closed our portion of the investigation. Other investigative agencies and the U.S. Attorney's Office continue to pursue this matter. However, it is unlikely the FEHBP will be able to recoup any of its losses.

OPM Retirement Program Fraud, Waste, and Abuse Case Summaries

Fraud, waste, or abuse that affects the CSRS or FERS programs harms the integrity of Federal retirement programs for civil servants and their surviving annuitants. During FY 2022, according to OPM, there were $325.81 million in improper payments in OPM retirement programs. Our investigations related to OPM's retirement programs help curtail improper payments and hold accountable those who exploit these programs.

We work closely with the Fraud Branch of OPM's Retirement Services program office and use proactive initiatives to develop leads for investigation. However, many retirement fraud cases are only discovered after years of damaging improper payments, costing tens of thousands of dollars to OPM retirement programs.

Several of the cases we report in this Semiannual Report involve identity theft, which is a common scheme in fraud, waste, and abuse involving OPM's retirement programs. We encourage OPM annuitants and survivor annuitants, or those overseeing their financial affairs, to protect themselves from identity theft and report any suspicious activity involving OPM annuity or survivor annuity payments via the OPM OIG Hotline.

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

Settlement Over Unreported Annuitant Death Returns $60,000

In October 2020, we received a fraud referral from the Retirement Services program office. A deceased survivor annuitant's January 2001 death had not been reported to OPM. Payments continued until May 2019, resulting in an overpayment of $256,754. OPM recovered $1,373 through the Department of Treasury's reclamation process, leaving an outstanding overpayment of $255,381.

We identified a person of interest based on our investigative review of bank records. The case was accepted for civil litigation by the U.S. Attorney's Office for the District of Western Texas. The subject of our investigation signed a settlement agreement and judgment documents on August 18, 2023, wherein based on their financial ability to make restitution, they will repay $60,000.

Investigation of $94,000 in Post-Death Survivor Annuity Payments Leads to Guilty Plea, Restitution

We received a fraud referral from the Retirement Services program office about a deceased survivor annuitant who died in April 2008. Their death was not reported to OPM, so direct deposits of the survivor annuity continued through July 2018.

With the decade-plus of payments after the survivor annuitant's death, OPM improperly paid a total of $94,692.

Our investigation found that after the survivor annuitant's death, more than 200 personal checks were cashed against the account using forged signatures.

This case was initially declined for prosecution because of difficulties coordinating with a State law enforcement partner and competing investigative priorities in that judicial district. However, because of the persistence of our criminal investigators, the case was accepted for prosecution and one individual was charged with theft of Government property. The individual pleaded guilty in June 2023. Per the plea agreement, $94,000 will be returned to OPM. Additional action related to sentencing is expected in this case.

Neighbor Steals Deceased Retired Annuitant's OPM Annuity Through Forged Checks

An OPM retired annuitant died in June 2016, but OPM continued making annuity payments until May 2019 when our proactive investigative efforts identified a grave record and we notified OPM so the agency could stop further monthly annuity payments. In total, OPM paid $128,983 in annuity payments after the retiree's death.

Our investigation uncovered that a neighbor of the retiree had obtained access to the bank account where OPM electronically deposited the deceased annuitant's annuity payments. The neighbor admitted during a voluntary interview that they had also obtained books of the decedent's blank personal checks and began to write themselves checks—forging the annuitant's signature—and depositing the money into a business account. The neighbor also acquired ownership of the deceased retiree's property and sold the property, keeping the proceeds.

The deceased annuitant's neighbor stole blank personal checks and used those stolen checks to deposit the stolen money into a business account. The neighbor also acquired and sold the deceased annuitant's property.

In May 2023, the neighbor was charged by criminal information in the U.S. District Court for the District of Nevada with one count of theft of public money and pleaded guilty to the charge. The court sentenced the neighbor to 36 months of supervised probation, 180 days of home confinement, and 1,000 hours of community service and ordered the neighbor to pay $127,670 in restitution.

Guilty Plea Results in $11,000 Restitution to CSRDF

We received a fraud referral from the OPM Retirement Services program office about a Civil Service Retirement and Disability Fund (CSRDF) annuitant who died in April 2018 but continued to receive payments through July 2020. OPM overpayments totaled $58,420; however, the agency was able to recover $13,187 through the Department of Treasury reclamation process, leaving a net overpayment of $45,232.

Our investigation uncovered several large cash withdrawals after the annuitant's death, as well as purchases at several retail stores, restaurants, and even a cruise line.

In an interview with our criminal investigators, the grandchild-in-law of the deceased annuitant said that their deceased spouse (the CSRDF annuitant's grandchild) managed the annuitant's account—but after the spouse died, the grandchild-in-law admitted that they used monies paid by OPM and another Federal agency. The subject offered to repay the money.

Further investigation found that $17,319 was money knowingly spent by the grandchild-in-law after the annuitant's death, as opposed to autopayments or other deductions.

The grandchild-in-law was charged by criminal information in the U.S. District Court for the Southern District of Illinois with theft of Government funds. On May 15, 2023, the grandchild-in-law pleaded guilty. They were sentenced to 24 months of probation, and the court ordered repayment of $17,319. Of that amount, OPM will receive $11,604 in restitution.

OPM Survivor Annuitant's Relative Pleads Guilty to Stealing $133,000 in Annuity Payments Over More Than a Decade

In May 2021, we received a referral from the OPM Retirement Services program office about a deceased survivor annuitant whose annuity had continued for more than 10 years after the survivor annuitant's November 2008 death. When OPM ended payments in May 2019, it had made a total of $143,296 in overpayments. OPM recovered $9,950 through Department of Treasury reclamation actions, but there remained $133,346 in outstanding monies.

Our investigation identified a relative of the deceased survivor annuitant as a person of interest. This person continued to use money from the survivor annuitant's bank account after the survivor annuitant's death. The money was withdrawn from Automated Teller Machines, spent on utility bills, or paid to medical providers, among other things.

In January 2023, a criminal information was filed against the subject of our investigation, charging them in the U.S. District Court for the Northern District of Alabama with one count of theft of Government funds. On March 21, 2023, this individual pleaded guilty to the charge. On September 12, 2023, they were sentenced to 3 years of probation and ordered to pay restitution of $133,345 to OPM.

Agency Oversight and Integrity Investigations

Investigating allegations of fraud, waste, abuse, or misconduct within OPM is one of the essential purposes of the OPM OIG. This can involve investigations of administrative issues that affect OPM employees, contractors, and/or investigations into allegations of criminal misconduct. The integrity-related investigations we conduct are often referred to us through the OIG Hotline or involve whistleblowers. 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 the integrity of OPM operations.

Per the Inspector General Act of 1978, as amended, we must report to Congress in the Semiannual Report the outcomes of investigations into allegations involving senior positions within OPM. In this Semiannual Report to Congress, we have no outcomes to report for any investigations into allegations involving senior positions within OPM. However, during this reporting period, we had the following integrity-related investigation. While we are not required to report on this investigation, we nevertheless believe it is representative of our work.

OPM Employee Pleads Guilty and is Sentenced for Multi-Million Dollar Contract Fraud

We received information from a Federal law enforcement partner about allegations that an OPM contracting officer had allegedly steered OPM contracts to an IT management and consulting firm cofounded by the contracting officer's spouse.

In August 2011, the OPM contracting officer proposed that OPM invite the IT company founded by their spouse to bid on an open contract—without notifying anyone of their connection to the

company. At the issuance of the contract, the spouse's name did not appear on company documents. A month after the contracting officer's proposal, OPM awarded the company the spouse founded a Blanket Purchase Agreement, which is an agreement established to fill repetitive needs for supplies and services. The contracting officer served as a point of contact and Contract Specialist for the contract with the IT company.

The contracting officer completed multiple disclosure forms and made multiple statements that did not reflect the conflict of interest between their work as the contracting officer and these contracts. In sum, between 2011 and 2023, companies associated with the OPM contracting officer or their spouse received over $10 million from OPM.

In sum, between 2011 and 2023, companies associated with the OPM contracting officer or their spouse received over $10 million from OPM.

On April 4, 2023, the OPM contracting officer was indicted in the U.S. District Court for the District of Columbia for violating Title 18 United States Code (U.S.C) § 208(a), Acts Affecting a Personal Financial Interest. On May 19, 2023, they pleaded guilty to the charge. On September 21, 2023, the former OPM contracting officer was sentenced to 24 months of probation, a $10,000 fine, and a $100 Special Assessment.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (5 U.S.C. § 8902a), we suspend or debar health care providers whose actions demonstrate that they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were a total of 38,761 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/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 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 405 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 1,316 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, State regulatory entities, 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 eligible family members.

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

Chiropractic Clinic Debarred Based on Ownership by a Debarred Provider

A debarred chiropractor continued to submit claims for services rendered to FEHBP enrollees during his period of debarment. As a result, our office debarred a chiropractic clinic the provider owned.

In November 2001, our office debarred a chiropractor based on his exclusion by HHS OIG. Our debarment and his HHS OIG exclusion remain in effect. In November 2022, the Government

Employees Health Association (GEHA) notified our office that they received claims for services rendered by the debarred provider during his debarment period.

As a result, in November 2022, we issued a notice to the provider reminding him that his OPM debarment prohibits him from participating in the FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans. We informed the debarred provider that his actions violated his debarment terms and that continued submission of FEHBP claims during his debarment period could be deemed violations of the Federal false claims statutes, potentially resulting in prosecution by a U.S. Attorney. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that a sanctioned provider owns or controls. The provider's violations prompted our ASG to investigate the debarred provider's affiliated entities. The investigation identified one chiropractic clinic owned by the debarred provider. As a result, we debarred the chiropractic clinic effective June 2023. The debarment of the chiropractic clinic will coincide with the debarment terms of the provider.

Our ASG identified and investigated this case.

Two Dental Clinics Debarred Based on Ownership by a Debarred Provider

A debarred dentist continued to submit claims for services rendered to FEHBP enrollees during his period of debarment. As a result, our office debarred two affiliated dental clinics.

In February 2012, our office debarred a dentist based on his exclusion by HHS OIG. Our debarment and his HHS OIG exclusion remain in effect. In November 2022, GEHA, an FEHBP health care carrier, notified our office that they received claims for services rendered by the debarred provider during his debarment period. As a result, in November 2022, we issued a notice to the provider reminding him that his OPM debarment prohibits him from participating in the FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans.

We informed the debarred provider that his actions violated his debarment terms and that continued submission of FEHBP claims during his debarment period could be deemed violations of the Federal false claims statutes, potentially resulting in prosecution by a U.S. Attorney. Also, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that a sanctioned provider owns or controls. Our regulations at 5 Code of Federal Regulations § 890.1003 define a control interest as, among other things, constituting the direct or indirect ownership of five percent or more of an entity or serving as an officer, director, or agent of an entity.

The provider's violations prompted our ASG to investigate the entities affiliated with the debarred provider. The investigation revealed that the debarred provider owned one dental clinic and held a controlling interest in another dental clinic. As a result, we debarred the two clinics effective June 2023. The debarments of the dental clinics will coincide with the debarment terms of the provider.

Our ASG identified and investigated this case.

Texas Medical Clinic Debarred Based on Ownership by a Debarred Provider

A debarred Texas physician continued to submit claims for prescriptions written to an FEHBP enrollee during his period of debarment. As a result, our office debarred a medical clinic the provider owned.

In December 2014, our office debarred a physician based on his exclusion by HHS OIG. Our debarment and his HHS OIG exclusion remain in effect. In January 2023, the National Association of Letter Carriers (NALC), an FEHBP health insurance carrier, notified our office that they received claims for prescriptions furnished by the debarred provider during his debarment period. The debarred provider wrote 21 prescriptions to one enrollee between December 1 and December 18, 2022. As a result, in January 2023, we issued a notice to the provider reminding him that his OPM debarment prohibits him from participating in the FEHBP and receiving payment of FEHBP funds, either directly or indirectly, for services or supplies furnished to any person enrolled in one of the FEHBP's health insurance plans.

We informed the debarred provider that his actions violated his debarment terms and that continued submission of FEHBP claims during his debarment period could be deemed violations of the Federal false claims statutes, potentially resulting in prosecution. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that a sanctioned provider owns or controls. The provider's violations prompted our ASG to investigate the entities affiliated with the debarred provider. The investigation identified one medical clinic owned and controlled by the debarred provider. As a result, we debarred the clinic effective August 2023. The debarment of the medical clinic will coincide with the debarment terms of the provider.

Our ASG identified and investigated this case.

District of Columbia Medical Clinic Debarred Based on Ownership by a Debarred Provider

A debarred physician in Washington, D.C., continued to submit claims for services rendered to FEHBP enrollees during his period of debarment. As a result, our office debarred a medical clinic the provider owns.

In May 2008, our office debarred a physician, based on his exclusion by HHS OIG. Our debarment and his HHS OIG exclusion remain in effect.

In May 2020, GEHA notified our office that they received claims for services rendered by the debarred provider during his debarment period. As a result, in August 2020, we issued a notice to the provider reminding him that OPM's debarment 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. Subsequently, in January 2023, the Foreign Services Benefits Plan (FSBP), an FEHBP health care carrier, notified our office that they received claims for services rendered by the debarred provider during his debarment period. As a result, in January 2023, we issued a second debarment notice to the provider.

We informed the debarred provider that his actions violated his debarment terms and that continued submission of FEHBP claims during his debarment period could be deemed violations

of the Federal false claims statutes, potentially resulting in prosecution by a U.S. Attorney. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that a sanctioned provider owns or controls. The provider's violations prompted our ASG to investigate the entities affiliated with the debarred provider. The investigation identified one medical clinic that the debarred provider owns. As a result, we debarred the clinic effective August 2023. The debarment of the medical clinic will coincide with the debarment terms of the provider.

Our ASG identified and investigated this case.

California Medical Service Company Debarred Based on State Licensure

In June 2022, a California medical service company pleaded guilty to transportation of stolen property. In July 2015, the entity transported, transmitted, and transferred in interstate commerce $5,000 or more in pre-retail medical products, namely approximately five infusion pumps with a cumulative value of approximately $7,500, knowing that the pumps had been unlawfully stolen, converted, or taken by fraud with the intent to permanently deprive the owner of their use. We determined that the California Department of State suspended the company's business license in January 2018.

Under 5 U.S.C. § 8902a(c)(1), OPM has the authority to debar a provider whose license to provide health care services or supplies has been revoked, suspended, restricted, or not renewed by a State licensing authority. As a result, we debarred the California medical service company effective August 2023. The debarment of the medical service company will be for an indefinite period coinciding with the period in which their license is suspended by the State of California.

Our ASG identified and investigated this case.

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 (known as the 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.

Although we have an ongoing evaluation, there were no evaluations completed during this reporting period.

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.

Postal Service Reform Act of 2022 Oversight Resources

The Postal Service Reform Act of 2022 (PSRA), enacted on April 6, 2022, tasked OPM with creating a new Federal health care program under the FEHBP for postal employees and their families called the Postal Service Health Benefits Program, or PSHBP. Congress appropriated $70.5 million (for fiscal year 2022 until expended) for OPM to establish the PSHBP, with the clear message that the agency needed resources to ensure successful implementation. Successful implementation is a priority not only for Congress, but for the agency and the Administration as well. We strongly believe that proactive, real-time oversight is essential and remains integral to helping the agency successfully implement this new program. To that end, the OPM OIG has continued during this reporting period to work with Congressional oversight and appropriations committees on requesting adequate resources to effectively oversee the accomplishment of this shared goal.

We have also met with the Congressional committees that authorized the landmark PSRA to discuss OPM OIG's current oversight initiatives and plans for future oversight. Because the PSRA set forth a tight deadline for PSHBP coverage to begin on January 1, 2025, OPM has several high-risk initiatives that must be accomplished in a short time frame, such as implementation of information technology and cybersecurity controls to process and protect highly sensitive health data. As we have shared with the agency and our Congressional stakeholders, the OPM OIG is actively committed to reviewing these efforts in real time so that any weaknesses or issues can be addressed before Federal funds are misspent or future members are put at risk.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries

Indictments and Criminal Informations	6
Arrests	6
Convictions	7
Criminal Complaints/Pre-Trial Diversion	0
Subjects Presented for Prosecution	28
Federal Venue	28
Criminal	12
Civil	16
State Venue	0
Local Venue	0
Expected Recovery Amount to OPM Programs	$3,164,270
Civil Judgments and Settlements	$254,326
Criminal Fines, Penalties, Assessments, and Forfeitures	$1,010,400
Administrative Recoveries	$1,812,835
Expected Recovery Amount for All Programs and Victims[1]	$36,864,836

Investigative Administrative Actions

FY 2023 Investigative Reports Issued[2]	193
Issued between October 1, 2022, and March 31, 2023	78
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment Actions	1
Personnel Suspensions, Terminations, or Resignations	0 [3]
Referral to the OPM OIG Office of Audits	0
Referral to an OPM Program Office	3

Administrative Sanctions Activities

FEHBP Debarments and Suspensions Issued	405
FEHBP Provider Debarment and Suspension Inquiries	1,316
FEHBP Debarments and Suspensions in Effect at the End of the Reporting Period	38,761

1 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.
2 The total number of investigative reports issued during the reporting period includes reports of investigations and summative investigative reports.
3 We report one resignation related to the integrity investigation detailed in this report. The resignation occurred during the previous Semiannual Report period. The resignation was dated March 31, 2023, with a final pay date of April 14, 2023, as part of a plea agreement.

Table of Enforcement Activities

Cases Opened	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations[4]	33	4	0	0	37
Preliminary Investigations[5]	42	6	0	3	51
FEHBP Carrier Notifications/ Program Office	906	12	0	2	918
Complaints – All Other Sources/Proactive[6]	163	3	0	18	184

Cases Closed	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	29	11	0	1	41
Preliminary Investigations	29	1	0	3	33
FEHBP Carrier Notifications/ Program Office	1,089	17	0	0	1,106
Complaints – All Other Sources/Proactive	132	2	0	18	152

Cases In-Progress[7]	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	120	24	0	2	146
Preliminary Investigations	27	4	0	1	32
FEHBP Carrier Notifications/ Program Office	96	0	0	0	96
Complaints – All Other Sources/Proactive	26	0	0	0	26

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

OIG Hotline Complaint Activity

OIG Hotline Complaints Received	1,789
Sources of OIG Hotline Cases Received	
Website	1,046
Telephone	601
Letter	108
Email	33
Other	1
OPM Program Office	
Healthcare and Insurance	**290**
Customer Service	37
Healthcare Fraud, Waste, and Abuse Complaint	143
Other Healthcare and Insurance Issues	110
Retirement Services	**743**
Customer Service	349
Retirement Fraud, Waste, and Abuse Complaint	95
Other Retirement Services Issues	299
Other OPM Program Offices/Internal Matters	**23**
Customer Service	4
Other OPM Program Fraud, Waste, and Abuse	8
Other OPM Program Issue	11
External Agency Issue (unrelated to OPM)	**733**
OIG Hotline Complaints Reviewed and Closed[8]	2,354
Outcome of OIG Hotline Complaints Closed	
Referred to External Agency	**86**
Referred to OPM Program Office	**593**
Retirement Services	505
Healthcare and Insurance	59
Other OPM Programs/Internal Matters	29
Referred to FEHBP Carrier	**106**
No Further Action	**1,565**
Converted to a Case	**4**
OIG Hotline Complaints Pending[9]	131
By OPM Program Office	
Healthcare and Insurance	18
Retirement Services	104
Other OPM Program Offices/Internal Matters	3
External Agency Issue (unrelated to OPM)	0
To be determined[10]	6

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

Appendices

Appendix I-A

Final Reports Issued With Questioned Costs for Insurance Programs

April 1, 2023, to September 30, 2023

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	9	$35,362,200
B.	Reports issued during the reporting period with questioned costs	5	$31,025,335[1]
	Subtotals (A+B)	14	$66,387,535
C.	Reports for which a management decision was made during the reporting period:	4	$16,110,556
	1. Net disallowed costs	N/A	$15,953,752
	a. Disallowed costs during the reporting period	N/A	$16,164,907[2]
	b. Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$211,155[3]
	2. Net allowed costs	N/A	$156,804
	a. Allowed costs during the reporting period	N/A	-$54,351[4]
	b. Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$211,155[3]
D.	Reports for which no management decision has been made by the end of the reporting period	10	$50,276,979
E.	Reports for which no management decision has been made within 6 months of issuance	8	$33,003,816

[1] Includes $46,692 in additional questioned costs from a report that was previously issued.
[2] Represents the management decision to support questioned costs and establish a receivable during the reporting period.
[3] Represents questioned costs determined by management to be allowable charges per the contract, subsequent to an initial management decision to disallow and establish a receivable. The receivable may have been set up in this period or previous reporting periods.
[4] Represents questioned costs (overpayments) which management allowed and for which no receivable was established. It also includes the allowance of underpayments to be returned to the carrier.

Appendix I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

April 1, 2023, to September 30, 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

April 1, 2023, to September 30, 2023

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$35,362,200
B.	Value of new audit recommendations issued during the reporting period	$31,025,335[1]
	Subtotals (A+B)	$66,387,535
C.	Amounts recovered during the reporting period	$15,953,752
D.	Amounts allowed during the reporting period	$156,804
E.	Other adjustments	$0
	Subtotals (C+D+E)	$16,110,556
F.	Value of open recommendations at the end of the reporting period	$50,276,979

1 Includes $46,692 in additional questioned costs from a report that was previously issued.

Appendix III

Final Reports Issued With Recommendations for Better Use of Funds

April 1, 2023, to September 30, 2023

Subject		Number of Reports	Dollar Value
A.	Reports for which no management decision had been made by the beginning of the reporting period	1	$6,140,755
B.	Reports issued during the reporting period with questioned better use of funds amounts	0	$0
	Subtotals (A+B)	1	$6,140,755
C.	Reports for which a management decision was made during the reporting period	0	$0
D.	Reports for which no management decision has been made by the end of the reporting period	1	$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

April 1, 2023, to September 30, 2023

Report Number	Subject	Date Issued	Questioned Costs
2022-ERAG-0013	BlueCross BlueShield of Massachusetts in Boston, Massachusetts	April 13, 2023	$53,442
2022-CAAG-0035	Claims Processed in Accordance with the Omnibus Budget Reconciliation Acts of 1990 and 1993 at All Blue Cross and Blue Shield Plans for Contract Years 2019 through 2021 in Washington, D.C.	June 27, 2023	$22,856,205
2022-SAG-012	Federal Employees' Group Life Insurance Program as Administered by the Metropolitan Life Insurance Company for Fiscal Years 2019 through 2022 in Bridgewater, New Jersey	July 17, 2023	$0
2022-SAG-015	UnitedHealthcare Dental Plan's 2024 Premium Rate Proposal for the Federal Employees Dental and Vision Insurance Program in Hartford, Connecticut, and Minnetonka, Minnesota	July 24, 2023	$0
2022-SAG-014	EmblemHealth Dental's 2024 Premium Rate Proposal for the Federal Employees Dental and Vision Insurance Program in New York, New York	July 28, 2023	$0
2022-SAG-018	Aetna Dental's 2024 Premium Rate Proposal for the Federal Employees Dental and Vision Insurance Program in Blue Bell, Pennsylvania	August 3, 2023	$0
2022-SAG-013	Blue Cross Blue Shield Federal Employee Program's Dental 2024 Premium Rate Proposal in Minneapolis, Minnesota	August 4, 2023	$0
2022-CRAG-0038	Health Alliance Plan in Detroit, Michigan	August 15, 2023	$0
2022-CRAG-032	Medical Mutual of Ohio in Cleveland, Ohio	August 21, 2023	$71,929
2022-ERAG-0022	Blue Shield of California Access – HMO in Oakland, California	August 21, 2023	$2,479,193
2022-ERAG-0021	Blue Shield of California in Oakland, California	September 26, 2023	$5,517,874
TOTAL			$30,978,643

Appendix V

Internal Audit Reports Issued

April 1, 2023, to September 30, 2023

Report Number	Subject	Date Issued
2022-IAG-0016	The U.S. Office of Personnel Management's Travel Charge Card Program in Washington, D.C.	April 18, 2023
2023-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	May 22, 2023
2022-IAG-0019	The U.S. Office of Personnel Management's Retirement Services' Settlement Process in Washington, D.C.	June 15, 2023

Appendix VI

Information Systems Audit Reports Issued

April 1, 2023, to September 30, 2023

Report Number	Subject	Date Issued
2022-ISAG-030	Information Systems General and Application Controls at Blue Cross and Blue Shield of Rhode Island in Providence, Rhode Island	May 1, 2023
2022-ISAG-036	Information Systems General and Application Controls at Health Alliance Medical Plans, Inc., in Champaign, Illinois	June 13, 2023
2022-ISAG-007	Information Technology Security Controls of the U.S. Office of Personnel Management's Benefits Plus System in Washington, D.C.	August 9, 2023
2022-ISAG-003	Information Systems General and Application Controls at Blue Cross of Idaho in Meridian, Idaho	August 10, 2023

Appendix VII

Summary of Reports More Than 6 Months Old Pending Corrective Action

As of September 30, 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	1	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 VII *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	2	0	29
4A-CI-00-15-011	Federal Information Security Modernization Act for Fiscal Year 2015 in Washington, D.C.	November 10, 2015	2	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	1	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
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	2	0	4

Appendix VII *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CI-00-17-030	Information Technology Security Controls of the U.S. Office of Personnel Management's SharePoint Implementation in Washington, D.C.	September 29, 2017	5	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	14	0	18
4A-CF-00-15-049	The U.S. Office of Personnel Management's Travel Card Program in Washington, D.C.	January 16, 2018	11	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	3	0	5
4A-CF-00-18-012	The U.S. Office of Personnel Management's Fiscal Year 2017 Improper Payments Reporting in Washington, D.C.	May 10, 2018	1	0	2
4A-HR-00-18-013	Information Technology Security Controls of the U.S. Office of Personnel Management's USA Staffing System in Washington, D.C.	May 10, 2018	2	0	4
4A-CI-00-18-038	Federal Information Security Modernization Act Audit Fiscal Year 2018 in Washington, D.C.	October 30, 2018	7	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

Appendix VII *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
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-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	2	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-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	6	0	23
4A-CI-00-19-029	Federal Information Security Modernization Act Audit Fiscal Year 2019 in Washington, D.C.	October 29, 2019	7	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

Appendix VII *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
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	7	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
1H-07-00-19-017	CareFirst BlueChoice's Federal Employees Health Benefits Program Pharmacy Operations as Administered by CVS Caremark for Contract Years 2014 through 2017 in Scottsdale, Arizona	July 20, 2020	3	0	8
4A-DO-00-20-041	Management Advisory Report - Delegation of Authority to Operate and Maintain the Theodore Roosevelt Federal Building and the Federal Executive Institute in Washington, D.C.	August 5, 2020	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	3	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	5	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-00-20-010	Federal Information Security Modernization Act Audit Fiscal Year 2020 in Washington, D.C.	October 30, 2020	8	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-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021	0	1	2

Appendix VII *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-HI-00-18-026	Management Advisory Report - FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021	1	0	4
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
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	0	1	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
2022-IAG-003	The U.S. Office of Personnel Management's Fiscal Year 2022 Consolidated Financial Statements in Washington, D.C.	November 14, 2022	15	0	15
2022-ISAG-0017	Federal Information Security Modernization Act Audit - Fiscal Year 2022 in Washington, D.C.	November 15, 2022	14	0	29

Appendix VII *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
2022-ERAG-0011	Premera BlueCross in Mountlake Terrace, Washington	December 12, 2022	2	0	10
2022-ISAG-0020	Information Systems General and Application Controls at Blue Cross Blue Shield of Kansas in Topeka, Kansas	December 14, 2022	0	3	6
2022-CRAG-004	MercyCare Health Plans in Janesville, Wisconsin	February 2, 2023	2	0	4
2022-CAAG-009	Claims Processing and Payment Operations at Premera Blue Cross in Mountlake Terrace, Washington	February 8, 2023	5	0	6
2022-CRAG-0010	The Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc., in Las Vegas, Nevada	February 15, 2023	4	2	20
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	10	0	12
2022-ISAG-0024	Information Systems General and Application Controls at American Postal Workers Union Health Plan in Glen Burnie, Maryland	February 27, 2023	0	2	23
2022-CAAG-0023	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	3	0	5
2022-CAAG-0014	Evaluation of COVID-19's Impact on FEBHP Telehealth Services and Utilization in Washington, D.C.	March 6, 2023	5	0	5
2022-ISAG-0027	Information Systems General and Application Controls at HealthPartners in Bloomington, Minnesota	March 20, 2023	2	3	5
Total			326	28	1078

[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 but 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 VIII

Most Recent Peer Review Results

As of September 30, 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 Tennessee Valley Authority Office of the Inspector General)*	July 8, 2021	Pass[1]
System Review Report on the National Railroad Passenger Corporation Office of Inspector General Audit Organization *(Issued by the U.S. Office of Personnel Management Office of the Inspector General)*	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 U.S. Office of Personnel Management Office of the Inspector General)*	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 U.S. Office of Personnel Management Office of the Inspector General)*	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 IX

Investigative Recoveries

April 1, 2023, to September 30, 2023

Investigative Recovery Area	Sum of Total Recovery Amount	Sum of OPM
Administrative Action	**$4,741,070**	**$1,812,835**
Healthcare and Insurance	**$4,597,482**	**$1,669,247**
Federal Employees Health Benefits Program (FEHBP)	$4,597,482	$1,669,247
Carrier Settlement Agreement	$4,428,576	$1,500,341
Claim Offsets	$168,906	$168,906
Retirement Services	**$143,587**	**$143,587**
Civil Service Retirement System & Federal Employees Retirement System	$143,587	$143,587
Administrative Debt Recovery	$143,587	$143,587
Civil Action	**$20,990,439**	**$254,326**
Healthcare and Insurance	$20,346,233	$179,326
Federal Employees Health Benefits Program (FEHBP)	$20,346,233	$179,326
Civil Action	$20,346,233	$179,326
Retirement Services	$644,206	$75,000
Civil Service Retirement System & Federal Employees Retirement System	$644,206	$75,000
Civil Action	$644,206	$75,000
Criminal Action	**$11,133,325**	**$1,097,108**
Healthcare and Insurance	**$10,048,183**	**$67,435**
Federal Employees Health Benefits Program (FEHBP)	$10,048,183	$67,435
Court Assessment/Fees	$200	$0.00
Criminal Fine	$1,000,000	$0.00
Criminal Judgement/Restitution	$9,047,983	$67,435
Office of Procurement Operations	**$10,100**	**$0**
Office of Procurement Operations	$10,100	$0
Court Assessment/Fees	$100	$0
Criminal Fine	$10,000	$0
Retirement Services	**$1,075,042**	**$1,029,673**
Civil Service Retirement System & Federal Employees Retirement System	$1,075,042	$1,029,673
Court Assessment/Fees	$100	$0
Criminal Judgement/Restitution	$1,074,942	$1,029,673
Grand Total	**$36,864,836**	**$3,164,270**

Index of Reporting Requirements

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

[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:

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

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

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

www.opm.gov/our-inspector-general

September 2023 | OIG-SAR-69