Office of the Inspector General

SEMIANNUAL REPORT TO CONGRESS

October 1, 2023 – March 31, 2024

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
$305,690,281	**$33,349,534**	**$1,545,750**

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	Special Review Report Issued	Management Advisories Issued	Investigations and Preliminary Investigations Closed	Indictments and Criminal Informations
17	1	1	0	59	8

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 and Correspondence Related to Federal Employees Health Benefits Program Providers
7	5	1918	1745	517	2022

Message from the Inspector General

On behalf of the employees of the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG), I am pleased to submit this Semiannual Report highlighting our work between October 1, 2023, and March 31, 2024.

I want to begin by thanking OPM Director Kiran Ahuja as her tenure comes to a close. Director Ahuja set the tone in OPM that cooperating with the OIG is a priority. Director Ahuja also gave a long overdue focus on closing open OIG recommendations. I look forward to continuing, and further fostering, the collaborative relationship the OIG has with Deputy Director Robert Shriver.

A priority area of the OIG's 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. We are proactively engaged in oversight in order to prevent fraud and improper payments before they happen and protect the integrity of the PSHBP.

The OPM OIG issued two reports on OPM's implementation of the PSHBP during this reporting period. One of the reports covered OPM's project management process and the other, a flash audit alert, identified concerns with the Authorization to Operate granted to the Carrier Connect system, used by OPM and health insurance carriers as a record for proposals, contracting decisions, communications, and data.

The OPM OIG needs additional resources across all of our components in order to fully carry out the needed oversight. The OIG has not, to date, received resources specifically for the PSHBP oversight. Investing funding into oversight now would help protect against future fraud, waste, and abuse in the PSHBP.

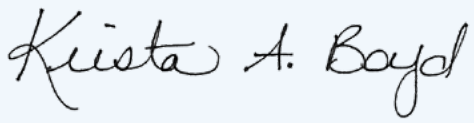
The PSHBP is just one portion of the work being conducted by the OPM OIG. Our total audit recommendations for recovery of funds exceeded $300 million during the reporting period. The management commitment to recover funds was over $33 million. One audit identified a significant system error at a health plan that resulted in FEHBP overpayments of more than $200 million.

The OPM OIG issued an evaluation report of OPM's management of initial retirement claims which identified needed improvements including, for example, improved transparency in reporting application processing times.

During the reporting period, our investigative efforts resulted in the recovery of over $1.5 million, seven arrests, and five convictions. These efforts included investigating a detoxification facility that targeted FEHBP members and billed for services not rendered ultimately costing FEHBP health insurance carriers $4.3 million. The owner of the facility pled guilty to health care fraud.

The OPM OIG issued 517 administrative sanctions of FEHBP health care providers during the reporting period. These suspensions and debarment actions are issued against providers who commit certain violations such as conviction of a crime.

These statistics and examples only represent a portion of the extraordinary work being done by the employees of the OPM OIG. We are constantly striving to improve and evolve so that we can most effectively provide independent, objective, and transparent oversight of OPM.



Krista A. Boyd
Inspector General

Mission

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

Vision

Oversight through Innovation.

Core Values

Vigilance

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

Integrity

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

Empowerment

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

Excellence

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

Transparency

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

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OIG Office Locations

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

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 located throughout the country 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 more than $64 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.

The following audits are representative of the reports that were finalized during the reporting period.

Audit of OPM's Disputed Claims Process for Calendar Years 2018 through 2020
Washington, D.C.
Report No. 2022-CAAG-001
December 20, 2023

We performed an audit of OPM's disputed health care claims process to determine if OPM had sufficient internal controls, including written policies and procedures, to review and make final determinations on appealed health care claims for calendar years 2018 through 2020. This process is a crucial component of the FEHBP, as it is the only non–judicial venue FEHBP members have to request reconsideration of their denied health care claims. The results of this first audit of OPM's disputed claims process revealed serious deficiencies concerning OPM's overall lack of internal controls over the process, including the following issues:

- OPM lacked policies and procedures to govern the disputed claims process, resulting in untimely and inconsistent disputed claims reviews and decisions that in some cases conflicted with guidance from the Centers for Disease Control and Prevention and the Consumer Bill of Rights. These issues have the potential to negatively impact the health and financial wellbeing of FEHBP members and impair their due process rights. The OIG continues to receive complaints via the OIG hotline regarding OPM's untimely and inconsistent disputed claims process.
- OPM lacked controls to sufficiently define disputed claims timeliness, communicating a 60-day standard for issuing a final decision on disputed claims reviews. OPM's own regulation allows 90 days for a final decision or status update on the review. OPM should specify the same time limitations and actions in the FEBHP benefit brochures as in the regulation.
- OPM failed to timely and appropriately process a Freedom of Information Act/Privacy Act request from an FEHBP member, leading to significant delays. OPM also did not timely issue a revised System of Records Notice when it transitioned to a new disputed claims system and inadvertently released the records of one FEHBP member to another FEHBP member without prior written consent.
- OPM had insufficient controls surrounding the retention of disputed claims data, which elevated the risk that data could be inappropriately communicated, incorrectly used, and insufficiently stored.

The final report included 15 procedural recommendations. OPM agreed with one recommendation, partially concurred with six recommendations, and disagreed with eight recommendations. All recommendations remain open.

Community-Rated Plans

The community-rated carrier audit universe covers approximately 140 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 that 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 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 health carriers. State-mandated traditional community-rated carriers are not subject to the MLR regulations and continue to be subject to the Similarly-Sized Subscriber Group comparison rating methodology.

> **MLR** is the portion of health insurance premiums collected by a health insurer that is spent on clinical services and quality improvement. The MLR for each insurer is calculated by dividing the amount of health insurance premiums spent on clinical services and quality improvement by the total amount of health insurance premiums collected. The MLR is important because it requires health insurers 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.

UnitedHeathcare Insurance Company, Inc.
Minnetonka, Minnesota
Report No. 2022-CRAG-037
October 30, 2023

We determined that the UnitedHealthcare Insurance Company (the Plan) did not comply with the provisions of its OPM contract and the laws and regulations governing the FEHBP premium rating for contract years 2019 through 2021.

UnitedHealthcare Insurance Company did not provide sufficient source documentation for several of the rating components, was noncompliant with various sections of the contract, and lacked sufficient internal controls over the FEHBP enrollment and claims processing systems.

Specifically, our audit identified the following:

- There was a discrepancy within the 2020 FEHBP benefit brochure related to the emergency room copayment. The brochure stipulated both a $150 and $200 copay for an emergency room visit, which led to confusion for members.
- There were variances in the Adjusted Community Rating claims and membership data.
- The Plan did not provide sufficient supporting documentation to verify that pharmacy rebates were removed from pharmacy claims in the 2019 through 2021 FEHBP premium rate developments.
- Our review of a judgmental sample of medical claims determined a claim system configuration issue, a record retention issue, copayment errors, an out-of-network providers issue, and a coordination of benefits error.
- The Plan did not comply with guidance issued by the OPM OIG Administrative Sanctions Group (ASG) for managing provider suspension and debarment from the FEHBP.
- The Plan's procedures for verifying ineligible family members were insufficient.
- During the audit, the Plan did not provide data we requested in a timely manner; in some cases, the Plan never provided the requested data.

The Plan agreed with all of the findings that were presented during our fieldwork. Due to the Plan not providing appropriate levels of documentary support during our fieldwork, some of the findings were developed during the preparation of the final report and did not receive an official response position upon issuance of the report. Since issuance of the report, the Plan has initially stated while there may have been misunderstandings during the audit, it will begin working on remedies for many of the recommendations.

Dean Health Plan
Madison, Wisconsin
Report No. 2023-CRAG-011
January 12, 2024

We determined that portions of Dean Health Plan's (the Plan) 2020 through 2022 FEHBP premium rate developments were not prepared in accordance with the laws and regulations governing the FEHBP and the requirements established by OPM.

Dean Health Plan's internal control systems over FEHBP premium rate developments, medical claims processing, and enrollment did not sufficiently meet the contractual criteria.

Specifically, our audit identified the following:

- The Plan's internal controls over the FEHBP premium rate development were insufficient in the following areas: (1) claims reductions; (2) catastrophic claims; (3) benefit factors; (4) Health Insurance Providers Fee; and (5) brochure inaccuracies.
- The Plan did not provide sufficient oversight of third-party vendors responsible for claim repricing.
- The Plan's claims system did not process non-participating provider and secondary payer claims in accordance with the terms of its contract with OPM.
- The Plan had insufficient FEHBP termination policies and procedures to effectively administer FEHBP enrollment during contract years 2020 through 2022.

In addition, the Plan's claims data submissions to the OIG did not meet the requirements of Carrier Letters 2021-17 and 2022-14.

The Plan agreed with the majority of the findings and has begun implementing the recommendations.

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 six final audit reports of experience-rated health plans (not including information security reports) participating in the FEHBP. The four final reports highlighted below contain recommendations for the return of more than $205 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 33 BCBS companies, has a Government-wide Service Benefit Plan contract with OPM to provide a health benefit plan authorized by the Federal Employees Health Benefits Act of 1959. The BCBS Association delegates authority to participating local BCBS plans throughout the United States to underwrite and process the health benefit claims of its Federal subscribers. Over 67% of all FEHBP members are enrolled in the BCBS Service Benefit Plan.

The BCBS Association established a Federal Employee Program (FEP) Director's Office in Washington, D.C., to provide centralized management of the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the BCBS Association, BCBS plans, and OPM. The BCBS Association also established an FEP Operations Center, the activities of which are performed by the Service Benefit Plan Administrative Services Corporation, an affiliate of CareFirst BCBS, located in Washington, D.C. These activities include acting as fiscal intermediary 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 South Carolina
Columbia, South Carolina
Report No. 2023-ERAG-004
February 20, 2024

Our audit of the FEHBP operations at BlueCross BlueShield of South Carolina (BCBS of SC) covered the Plan's miscellaneous health benefit payments and credits (such as cash receipts and refunds of provider overpayments), administrative expense charges, cash management activities and practices, and fraud and abuse program activities. We questioned $43,461 in health benefit refunds, cash management activities, and lost investment income.

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

Except for these questioned amounts, we concluded overall that BCBS of SC'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 SC 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 SC complied with the communication and reporting requirements for submitting fraud and abuse cases to the OIG.

Blue Cross Blue Shield of North Carolina
Durham, North Carolina
Report No. 2023-ERAG-005
February 26, 2024

Our audit of the FEHBP operations at Blue Cross Blue Shield of North Carolina (BCBS of NC) covered the Plan's miscellaneous health benefit payments and credits (such as cash receipts and refunds of provider overpayments), administrative expense charges, statutory reserve payments, cash management activities and practices, and fraud and abuse program activities. We questioned $954,142 in health benefit charges, administrative expense overcharges, cash management activities, and lost investment income, and identified a procedural finding regarding the Plan's fraud and abuse program activities. Our most significant finding was that BCBS of NC, because of a lack of due diligence with recovery efforts, had not recovered and/or returned provider offset refunds of $642,579 to the FEHBP for 163 claim overpayments. Another significant finding was that BCBS of NC overcharged the FEHBP $258,550 for administrative expenses related to non-recurring project costs.

The BCBS Association and BCBS of NC agreed with all questioned amounts. As part of our review, we verified that BCBS of NC returned $311,563 of the questioned amounts to the FEHBP. As of the end of this reporting period, one monetary recommendation remains open for questioned provider offset refunds of $642,579.

The audit disclosed no significant findings pertaining to either (1) BCBS of NC's statutory reserve payments or (2) BCBS of NC's cash management activities and practices related to FEHBP funds. Overall, we determined that BCBS of NC charged statutory reserve payments to the FEHBP in accordance with the contract, applicable laws, and Federal regulations. We also determined that BCBS of NC handled FEHBP funds in accordance with the contract, applicable laws, and Federal regulations concerning cash management in the FEHBP.

Audit of the Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021
Washington, D.C.
Report No. 2023-CAAG-001
November 6, 2023

This audit identified a significant system error at Anthem Blue Cross of California (the Plan) that resulted in FEHBP overpayments of more than $200 million. Specifically, the audit identified the following:

- A system error that caused claims for some non-participating providers to be paid at billed charges instead of the local plan allowance, resulting in $203,231,446 in program overcharges to the FEHBP. This error occurred after a 2019 program benefit change required non-emergency services at non-participating outpatient facilities to be paid at the local plan allowance. The benefit change required an update to the Plan's claims processing system to accurately relay the local plan allowance from the Plan's system to Anthem's corporate claims processing system. After further review, we determined that the local plan allowance for these types of claims was not being relayed to Anthem's corporate claims processing system, causing these claims to pay at billed charges and resulting in significant FEHBP overpayments. The Plan did identify this issue prior to the audit, and it was remediated in 2021. However, the overcharges that occurred while the error existed were not recovered prior to the audit.
- Claims that were paid based on an incorrect provider network status, resulting in $467,409 in net program overcharges ($491,324 in overpayments and $23,915 in underpayments).
- A procedural finding involving noncompliance with our debarment and suspension guidelines.

The final report included three monetary and four procedural recommendations. The Plan agreed with one monetary and two procedural recommendations, disagreed with two monetary recommendations, and did not state whether it agreed or disagreed with two procedural recommendations. In responding to our monetary recommendations, the BCBS Association disagreed that the overcharges should be disallowed due to its efforts in discovering the system error, notifying the OIG about the error, and initiating recovery efforts on both monetary findings. As of the end of this reporting period, two monetary recommendations and one procedural recommendation were closed and four recommendations remain open.

Global Audits

Global audits of BCBS plans are crosscutting reviews of specific issues we determine are likely to cause improper payments. These audits review one aspect of all 60 BCBS plans offered by the 33 participating BCBS companies, as opposed to reviewing multiple aspects of one individual plan.

We issued one final global audit report related to the processing and payment of claims in accordance with the provider's network status (for example: preferred, participating, non-participating).

Audit of Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021
Washington, D.C.
Report Number 2023-CAAG-009
February 15, 2024

This audit identified 1,724 claims that were paid at the incorrect provider network status, which resulted in net program overcharges of $1,038,050 ($1,083,534 in overpayments and $45,484 in underpayments). The final report included two monetary recommendations and one procedural recommendation. The BCBS Association agreed with most of the recommendations and is in the process of implementing corrective actions to address the recommendations and recover the identified overpayments that can be recovered. All recommendations remain open.

Information Systems Audits

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

Our audit universe encompasses all 51 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 three IT system audit reports during the reporting period. Selected notable reports are summarized below.

Federal Information Security Modernization Act Audit for Fiscal Year 2023
Washington, D.C.
Report Number 2023-ISAG-006
November 22, 2023

The Federal Information Security Modernization Act (FISMA) Inspector General (IG) reporting metrics use a maturity model evaluation system derived from the National Institute of Standards and Technology's (NIST) Cybersecurity Framework. There are five levels in the maturity model, ranging from ad hoc to optimized. The Cybersecurity Framework is comprised of nine domain areas and the weighted averages of the domain scores are used to derive the agency's overall cybersecurity score. In Fiscal Year (FY) 2023, OPM's cybersecurity maturity level measured 3 – Consistently Implemented, which is generally considered to be effective.

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

Risk Management – OPM has defined an enterprise-wide risk management strategy through its risk management council. OPM has developed and implemented policies, procedures, and processes to maintain an up-to-date inventory of its hardware and software.

Supply Chain Risk Management (**SCRM**) – OPM has defined and communicated an organization-wide SCRM strategy that addresses risk appetite and tolerance, strategies and controls, processes for consistently evaluating and monitoring supply chain risk, and approaches for implementing and communicating the SCRM strategy.

Configuration Management – OPM has developed, documented, and disseminated baseline configurations and standard configuration settings for its information systems. The agency has an established configuration change control process.

Identity, Credential, and Access Management (**ICAM**) – OPM has defined and documented a comprehensive ICAM Strategy and Charter detailing its goals and objectives. OPM has enforced multifactor authentication with Personal Identity Verification cards.

Data Protection and Privacy – OPM has established the Office of the Executive Secretariat and Privacy and Information Management, which has defined and communicated OPM's privacy program plan and related policies and procedures. However, OPM has not consistently dedicated appropriate resources to the program or ensured that individuals are consistently performing the privacy roles and responsibilities that have been defined across OPM.

Security Training – OPM has implemented a security training strategy and program. OPM stated that there were no new resource gaps within their workforce. However, a current gap analysis needs to be conducted to identify any weaknesses in specialized training.

Information Security Continuous Monitoring (**ISCM**) – OPM has established ISCM policies for its environment. OPM's continuous monitoring strategies address security control monitoring at the organization, business unit, and individual information system levels. However, OPM does not consistently document lessons learned to make improvements to the ISCM policies and strategy.

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

Contingency Planning – OPM has implemented several of the FISMA requirements related to contingency planning and continues to improve upon maintaining its contingency plans as well as conducting contingency plan tests on a routine basis.

Audit of the Information Technology Security Controls of the U.S. Office of Personnel Management's Enterprise Mainframe System
Washington, D.C.
Report Number 2023-ISAG-016
February 26, 2024

The Enterprise Mainframe is one of OPM's major IT systems. We completed a performance audit of the system to ensure that its security controls meet the standards established by FISMA, NIST, the Federal Information System Controls Audit Manual, and OPM's Office of the Chief Information Officer. Our audit of the system's IT security controls determined that it complies with FISMA requirements. We determined that the Enterprise Mainframe security categorization is appropriate and that it complies with Privacy Act requirements. The system's security requirements were properly documented and monitoring of security controls is consistent with OPM policy. Furthermore, the system's security controls we tested follow NIST guidance. We had no recommendations for corrective action on this audit.

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. In addition, our auditors work with program offices to resolve and close internal audit recommendations.

Two notable reports are summarized below.

OPM's Consolidated Financial Statements Audits

The Chief Financial Officers Act of 1990 (Public Law 101–576) requires OPM's IG or an independent external auditor, as determined by the IG, to audit the agency's financial statements in accordance with *Government Auditing Standards* issued by the Comptroller General of the United States. OPM contracted with Grant Thornton LLP, an independent certified public accounting firm, to audit the consolidated financial statements as of September 30, 2023, and September 30, 2022. The contract required that the audit be performed in accordance with generally accepted government auditing standards (GAGAS) and Office of Management and Budget (OMB) Bulletin No. 24-01, *Audit Requirements for Federal Financial Statements*.

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

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

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

In connection with the audit contract, we reviewed Grant Thornton's report and related documentation and made inquiries of its representatives regarding the audit. To fulfill our audit responsibilities under the Chief Financial Officers Act for ensuring the quality of the audit work performed, we conducted a review of Grant Thornton's audit of OPM's FY 2023 Consolidated Financial Statements in accordance with *Government Auditing Standards*. Specifically, we:

- Provided oversight, technical advice, and liaison to Grant Thornton auditors;
- Ensured that audits and audit reports were completed timely and in accordance with the requirements of GAGAS, OMB Bulletin 24-01, and other applicable professional auditing standards;

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

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

OPM's FY 2023 Consolidated Financial Statements
Washington, D.C.
Report Number 2023-IAG-017
November 13, 2023

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

- The consolidated balance sheets as of September 30, 2023, and September 30, 2022;
- The related consolidated statements of net cost, changes in net position, and the combined statements of budgetary resources for the years then ended;
- The related notes to the financial statements;
- The individual balance sheets of the Retirement, Health Benefits, and Life Insurance programs (the Programs), as of September 30, 2023, and September 30, 2022;
- The related individual statements of net cost, changes in net position, and budgetary resources for the years then ended; and
- The related notes to the individual financial statements.

Grant Thornton reported that OPM's consolidated financial statements and its Programs' individual financial statements as of and for the fiscal years ended September 30, 2023, and September 30, 2022, were presented fairly in all material respects, and in conformity with U.S. Generally Accepted Accounting Principles. Grant Thornton's audits generally include an identification of any internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

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

Information Systems Control Environment—During FY 2023, deficiencies noted in FY 2022 continued to exist and Grant Thornton's testing identified similar control issues in both the design and operation of key controls. Grant Thornton believes that, in many cases, these deficiencies continue to exist because of one, or a combination, of the following:

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

The information system issues identified in FY 2023 included repetitive conditions consistent with prior years, as well as new deficiencies. The deficiencies in OPM's information systems control environment are in the areas of Security Management, Logical Access, Configuration Management, and Interface/Data Transmission Controls. In the aggregate, these deficiencies are considered to be a Material Weakness.

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

OPM did not concur with Grant Thornton's reported FFMIA Section 803(a) noncompliance with financial systems. OPM reported noncompliance with the FFMIA system requirements in FY 2022 due to the material weakness reported in the information system control environment. On October 1, 2022, OPM migrated its mainframe-based core financial system for Trust Funds accounting, the Federal Financial System, to the AIOS (ARC Integrated Oracle Solution), part of Treasury's shared services platform. OPM stated that the migration of its core accounting systems from legacy systems to third-party services, as well as its existing full shared services with the U.S. Department of Transportation, Federal Aviation Administration's Enterprise Service Center transactional accounting support and Delphi platform allows OPM to report compliance with FFMIA and close the material weakness from the prior year. Grant Thornton reviewed the additional context provided in OPM's response and concluded that OPM's response does not affect the assessments of the material weakness and the finding of substantial noncompliance with the relevant Federal financial management systems requirements.

OPM's Purchase Card Program
Washington, D.C.
Report No. 2023-IAG-008
February 20, 2024

Our auditors completed a performance audit of OPM's Purchase Card Program. The Office of Procurement Operations (OPO) is responsible for administering OPM's Purchase Card Program and providing oversight and administration assistance for the Purchase Card Program throughout OPM at the agency level.

The objectives of our audit were to determine whether OPM's internal controls for its purchase card and convenience check program were adequately developed and implemented to prevent and detect purchase card fraud, misuse, or abuse. Specifically, the objectives were to determine if OPO

has proper internal controls in place for the issuance and closing of purchase cards; ensure OPM's purchase card transactions and convenience checks were properly authorized/approved, adequately documented, reallocated, monitored, and for legitimate business purposes; and determine if all program participants, including cardholders, Agency/Organization Program Coordinators, and Approving Officials were trained in charge card management.

Our audit found that OPO needs to strengthen their internal controls over OPM's Purchase Card Program. While we determined that OPO has proper internal controls in place for the closing of purchase card accounts, our audit identified the following areas requiring improvement:

- OPO is using outdated policies and procedures, dated August 14, 2018, that do not reflect recent organizational changes or clearly define all roles and responsibilities.
- We identified purchase card transactions totaling $599,962 that did not have all the required documents to support the purchases.
- All 11 convenience check transactions for checks issued between October 1, 2021, and March 31, 2023, (totaling $2,134) did not have all the required documentation to support the purchases.
- There were inconsistencies with how OPO assessed the documentation used in their review in 20 out of 61 cardholder reviews. Furthermore, the checklists that were used in OPO's review were not thoroughly completed by the Agency/Organization Program Coordinators.
- All 13 new cardholders (those who received a new card between October 1, 2021, and March 31, 2023) generally met the requirements for receiving a purchase card. However, none of the 13 cardholders had the required *Responsibility Acknowledgement Form* in their file.
- Training records were outdated or incomplete. We found 1 out of 36 Approving Officials was missing documentation to support completion of training and 3 were missing documentation to show that training was completed in a timely manner. In addition, 7 out of 36 Approving Officials and 3 out of 17 cardholders did not complete training within the required timeframe.
- OPO's report to the General Services Administration was submitted by the deadline and included all required statistical and narrative information; however, not all statistical data was supported.

OPO concurred with all 12 of our recommendations.

Special Audits

In addition to health insurance and retirement programs, OPM administers various other benefit programs for Federal employees, annuitants, and their 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 (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 an audit conducted by the Special Audits Group during this reporting period.

Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc., for Contract Years 2016 through 2021
Jacksonville, Florida and Cranberry Township, Pennsylvania
Report Number 2022-SAG-029
March 29, 2024

We completed a performance audit of the American Postal Workers Union Health Plan's (the Carrier) pharmacy operations as administered by Express Scripts, Inc. (the PBM). Our audit consisted of a review of the administrative fees, annual accounting statements, claims eligibility and pricing, drug manufacturer rebates, fraud and abuse program, and performance guarantees for the FEHBP pharmacy operations during contract years 2016 through 2021.

We found that the PBM overcharged the Carrier and the FEHBP $44,882,688 (including lost investment income) by not passing through all discounts and credits related to prescription drug pricing as required under the PBM Transparency Standards found in the Carrier's contract with OPM.

Specifically, our audit identified the following six findings that required corrective action. The findings occurred across all years of the audit scope unless otherwise noted.

- The Carrier overstated pharmacy costs in its annual accounting statements for calendar years 2018 through 2021.
- The FEHBP did not receive pass-through transparent drug pricing from the PBM for retail pharmacy claims, resulting in a $14,368,884 overcharge.

- The FEHBP did not receive several of the drug purchasing discounts collected by the PBM for drugs filled by its own mail order warehouses and specialty pharmacies, resulting in a $6,823,263 overcharge.
- The PBM failed to return $2,568,765 in retail pharmacy claim transaction fees that it was credited for the Carrier's retail prescription drug benefits.
- The FEHBP did not receive a portion of the drug manufacturer rebates collected by the PBM, resulting in a $5,281,746 overcharge.
- The PBM's sister company, Ascent Health Services, erroneously withheld a portion of the FEHBP's drug manufacturer rebates in 2019 and 2020, resulting in $15,840,030 due to the Carrier and the FEHBP. The Plan PBM agreed to $14,452,616 from this finding. The amount was recovered during our audit.

No audit findings were identified from our reviews of the administrative fees, claims eligibility, fraud and abuse program, and performance guarantees.

Express Scripts overcharged the American Postal Workers Union Health Plan and the FEHBP $45 million due to its failure to implement the PBM Transparency Standards required by OPM.

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, and 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), FEHB, and FEGLI programs. More than 8 million current and retired Federal civilian employees and their eligible family members receive benefits through these OPM programs.

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 eight criminal indictments or criminal informations; seven arrests; five convictions; and the return of $1,545,750 to OPM programs. We also highlight cases representative of our investigative efforts, trends, and oversight activities and 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. During this 6-month reporting period, our work has included: issuing an urgent fraud alert, conducting casework involving the OPM OIG's ongoing efforts to investigate bad actors who take advantage of the opioid epidemic and substance abuse crisis (including unethical substance abuse treatment facilities), and investigating other costly or dangerous health care and retirement frauds.

Fraud Alert: Scammers Using Discontinued Employee Express Customer Service Phone Number

In February 2024, we issued a fraud alert after a partner OIG notified us that several members of its agency contacted a discontinued customer service number related to Employee Express and may have been exposed to a potential fraudster requesting financial or personal information. After being notified of the concern, we contacted OPM to determine whether the number was still active and then immediately released a fraud alert on the OPM OIG website and to the IGs of the agencies suspected to be most at risk (because the phone number was previously printed on materials provided to staff or retirees). The fraud alert is reprinted here.

UNITED STATES OFFICE OF PERSONNEL MANAGEMENT

Washington, DC 20415

February 22, 2024

Special Fraud Alert: Scammers Using Discontinued Employee Express Customer Service Phone Number

The U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) has recently become aware that a discontinued customer service phone number (888-353-9450) previously associated with OPM's Employee Express website is currently in use by fraudsters/bad actors who have practiced financial exploitation tactics.

The OPM OIG is warning the public, particularly Federal employees and annuitants, not to call this number.

Do not call the 888-353-9450 phone number.
This number is currently in use by fraudsters.

This phone number does not contact customer service representatives for Employee Express or the U.S. Department of State's Annuitant Express.

This phone number was provided on U.S. Department of State human resources notices to employees and Foreign Service retirees. It may also be or have been provided on other participating Federal agencies' human resources notices or information. This customer service phone number is no longer in use by OPM or the Federal Government.

The Department of State's Annuitant Express is accessed via Employee Express. Employee Express is accessed using a PIV Smartcard or Login.gov.

If You Need to Contact Employee Express or Your Agency Benefits Officer

If you need assistance using Employee Express, use the Submit Help Request link in the upper right corner of the Employee Express login page. There is currently no customer service phone number in use for Employee Express.

Direct questions about specific personnel and payroll information to your servicing personnel-payroll office. OPM provides a list of Federal agency benefits officers on its website.

If You Believe You are the Victim of a Scammer Using the Phone Number in this Alert

If you think you gave personal information to a scammer, go to http://www.identitytheft.gov for steps you can take to protect your identity. Notify financial institutions and protect your accounts.

ReportFraud.ftc.gov is the Federal Government's website where you can report fraud, scams, and bad business practices. Please remember that legitimate Government representatives will never ask for sensitive personal information such as logins, PINs, or passwords or for financial information such as credit card numbers, bank account numbers, or other financial account information.

Health Care Fraud, Waste, and Abuse Case Summaries

Health care fraud investigations are most of our Office of Investigations' case activities. We investigate a range of health care fraud schemes, including cases involving illegal and improper distribution of opioids, treatment centers that take advantage of patients trying to receive treatment for their addiction, and common schemes such as inflated or fraudulent billing and violations of the False Claims Act. Because the FEHBP continues to be excluded from the Anti-Kickback Statute, we provide examples of investigations negatively affected by this ongoing issue as well.

Third-Party Medical Billing Company Owner Sentenced to 144 Months of Imprisonment

In January 2019, we received a referral from a Federal law enforcement partner about potential fraud involving a third-party medical billing company allegedly seeking extremely high reimbursement amounts by submitting false claims.

As part of the scheme, the medical billing company's owner and associates called health insurance carriers and impersonated patients. In these calls, they implored the health insurers to pay more money so that the "patient" would not be responsible for the bills. The FEHBP paid more than $6.1 million related to the allegations involved in this scheme.

In August 2019, the owner was indicted in the United States District Court in the Eastern District of New York on charges of wire fraud and aggravated identity theft. Allegedly, they continued to engage in fraudulent activities during the claims appeal process. In December 2019, a superseding criminal indictment filed in the U.S. District Court for the Eastern District of New York charged the owner with conspiracy to commit health care fraud, health care fraud, wire fraud, aggravated identity theft, and engaging in a money laundering conspiracy.

In June 2022, the owner was found guilty of all the aforementioned charges except engaging in a money laundering conspiracy. On February 2, 2024, the owner was sentenced to 144 months of imprisonment and 2 years of supervised release afterwards. The court ordered restitution of $336 million and forfeiture of $63 million. The exact amount to be returned to each involved party, including the FEHBP, has not yet been determined.

Owner of Detoxification Facility That Targeted FEHBP Members Pleads Guilty

We received a case referral from a Federal law enforcement partner about a detoxification facility that billed for services not rendered, even billing for services after eviction from its location.

The facility specifically targeted FEHBP members. The more than 25 FEHBP members whose information was used in the scheme had all been patients at the facility previously. Personally identifiable information was used to submit false claims without alerting the FEHBP members. In all, the fraud cost FEHBP health insurance carriers $4.3 million.

The owner of the detoxification center also took out a $150,000 Economic Injury Disaster Loan based on allegedly misrepresented application information.

The owner was indicted in the U.S. District Court for the Southern District of Florida on one count of health care fraud. On January 31, 2024, the owner pleaded guilty to the charge. Further judicial action related to sentencing in this case is expected. The owner's assets are also under forfeiture, which will be used to provide restitution to the FEHBP.

Pharmaceutical Manufacturer Pleads Guilty to Introducing Adulterated Drugs into Interstate Commerce

In May 2021, we received a request for the FEHBP's financial exposure to a fraud scheme where a prescription drug manufacturer allegedly manufactured medicine containing an ingredient made at a Mexican laboratory in violation of the Food and Drug Administration's manufacturing process regulations.

The FEHBP had paid $451,882 for medications made with the ingredient not manufactured according to the approved formulation.

On March 6, 2024, the pharmaceutical manufacturer pleaded guilty to introducing adulterated drugs into interstate commerce. Pursuant to the plea agreement, the pharmaceutical manufacturer agreed to a 3-year deferred prosecution agreement, a fine and forfeiture amount of $1.5 million, and to implement a compliance program with an independent compliance monitor. Additionally, it paid $2 million to resolve its civil liability under the False Claims Act. The FEHBP will receive $505,595 from these judicial outcomes.

Two Doctors Arrested for Illegally Providing Opioids

In July 2023, we received a case referral from a Federal law enforcement partner about two doctors who allegedly billed excessively or billed for services not rendered, including billing for injections but providing opioids to the patients in place of the injections (regardless of complaint or diagnosis).

FEHBP insurance carriers paid $144,771 in medical claims between January 2018 and July 2023 to these doctors. Our investigation found that the doctors did not administer the injections for which they billed.

Both doctors were indicted in the U.S. District Court for the Northern District of Texas on 13 counts of health care fraud and unlawful distribution of a controlled substance. The doctors were arrested at Dallas Fort Worth International Airport.

Further judicial action is expected in this case. These individuals are presumed innocent unless or until their guilt is established beyond a reasonable doubt in a court of law.

Updates to Previous Investigations

The health care cases investigated by the OPM OIG Office of Investigations are complicated white-collar criminal, civil, and administrative investigations with complex schemes that often take years of investigation and legal processes before resulting in recoveries, restitutions, or sentencings. These cases require our special agents to remain in contact with our partners at the U.S. Department of Justice, U.S. Attorneys' Offices (USAOs), and other law enforcement agencies to provide updates, program support and information, and more.

In this section, we provide updates to two investigations we reported in previous Semiannual Reports to Congress. For both cases, these updates highlight new actions occurring in this reporting period as part of our years-long involvements in the investigations of complex and harmful health care fraud schemes. These cases demonstrate how our investigative responsibilities end only when the judicial process resolves.

Update: Pennsylvania Pill Mill Broken Up
In our Semiannual Report for October 1, 2018, through March 31, 2019, we reported on an investigation ("Pennsylvania Pill Mill Broken Up") that at the time had cost the FEHBP $134,299 in fraudulent claims and presented a grave risk of patient harm. As our earlier case summary reported:

> The [involved medical providers] were allegedly billing for services not rendered and medically unnecessary services in order to prescribe Schedule II narcotics, including opioids like oxycodone, and routinely ignoring the warning signs of addiction or drug diversion. Physicians at the provider also allegedly operated without a valid [Drug Enforcement Administration] license, billed for services not rendered, and issued controlled substances without medical need or beyond medical guidelines. Some patients allegedly paid cash for opioid prescriptions under the guise of "office visit" fees or exchanged sexual favors with the providers for these drugs.

Five years later, this case continues to generate case activities as the medical providers involved in the scheme face the legal consequences for their actions. This case required our investigating case agent to continue to liaise with the USAO prosecuting the case.

Since March 2019:

- One individual pleaded guilty to maintaining a drug-involved premises, aiding and abetting, and conspiring to unlawfully distribute Schedule II controlled substances (February 2020);
- A doctor pleaded guilty to maintaining a drug-involved premises, aiding and abetting, and conspiring to unlawfully distribute Schedule II controlled substances (March 2020);
- A doctor pleaded guilty to three counts of distribution of controlled substances (October 2021);
- The ringleader of this scheme was sentenced to 107 months in prison and a $100,000 fine for maintaining a drug-involved premises and conspiracy to distribute a controlled substance (December 2023);
- One individual was sentenced to 2 years of probation and a $1,000 fine for maintaining a drug-involved premises and conspiracy to distribute a controlled substance (February 2024); and
- A doctor was sentenced to 30 months in prison, 3 years of supervised release with 1 year of home confinement, and a $1,000 fine for maintaining a drug-involved premises and conspiracy to distribute a controlled substance (February 2024).

The Office of Investigations has for years stressed the significance of our opioid-related investigations, and this case is a successful example of how that priority is protecting FEHBP members.

Update: Rural Hospital and Substance Abuse Treatment Pass-Through Scheme Broken Up
In our Semiannual Report for April 1, 2019, to September 30, 2019, we presented a rural hospital pass-through billing fraud scheme ("Rural Hospital and Substance Abuse Treatment Pass-Through Scheme Broken Up") and provided an update in our Semiannual Report for April 1, 2022, through September 30, 2022, when two individuals were convicted for their role in the scheme ("Two Individuals Convicted in $1.4 Billion Health Care Fraud Scheme Involving Rural Hospitals in Florida, Georgia, and Missouri"). As we noted in the most recent update, "the individuals promised to save these rural hospitals from closure by turning them into laboratory testing sites, but [...] [a]fter private insurance companies began to question the billings, [the perpetrators] would move on to another rural hospital, leaving the rural hospitals they took over in the same or worse financial shape than before their acquisition."

This fraud cost the FEHBP millions of dollars and years of OPM OIG and other law enforcement partners' investigative efforts to resolve. The scheme, which relied on urinalysis testing and substance abuse treatment facilities, took advantage of both struggling rural hospitals and patients affected by the opioid and substance abuse crisis.

On December 15, 2023, one individual involved in the scheme was sentenced to 100 months in prison and 36 months of probation, and a second individual was sentenced to 75 months in prison and 36 months of probation. Both of these individuals had been convicted of conspiracy to commit health care fraud and wire fraud, five counts of health care fraud, and conspiracy to commit money laundering of proceeds greater than $10,000.

Preparations for the Postal Service Health Benefits Program

The OPM OIG Office of Investigations has taken proactive steps to prepare for the Postal Service Health Benefits Program (PSHBP) as it continues to progress towards disbursing benefits in 2025. Our activities this semiannual reporting period include liaising with the OPM Healthcare & Insurance program office.

At this time, we do not have any publicly reportable investigative activities related to the PSHBP. We anticipate oversight of the PSHBP will bring unique challenges. Among these will be working with OPM to utilize its first insurance-related central enrollment portal to identify potential improper payments to ineligible members. We continue to work with OPM to address concerns about ineligible members using Federal health benefits.

Investigations Negatively Affected by the FEHBP's Ongoing Exclusion from the Anti-Kickback Statute

The FEHBP is excluded from the Anti-Kickback Statute. This negatively affects some OPM OIG investigations, causing FEHBP improper payments to go unrecovered.

When health care fraud cases are pursued based on violations of the Anti-Kickback Statute, the FEHBP is often ineligible to receive restitution. FEHBP losses—sometimes millions of taxpayer dollars—go unrecovered. There is often no alternative path to recourse for OPM.

The Anti-Kickback Statute's exclusion will also affect the 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 following cases are examples of unrecovered FEHBP losses in cases negatively affected by the FEHBP's ongoing exclusion from the Anti-Kickback Statute during this reporting period.

- We received a *qui tam* filed in the U.S. District Court for the Eastern District of Michigan alleging that a medical company engaged in a fraudulent drug discounting scheme that violated the Anti-Kickback Statute. Because the allegations were specific to violations of the Anti-Kickback Statute and the FEHBP is excluded from that law, we closed our case without determining the loss to the FEHBP. In cases like this one, when there is no chance of the FEHBP receiving restitution, the investigative resources of OPM OIG are too finite for our staff to determine what proportion of the millions—or hundreds of millions—of dollars paid to the providers is an actual loss related to the alleged fraud.

- We received a *qui tam* filed in the U.S. District Court for the District of Massachusetts alleging that a pharmaceutical company engaged in the illegal promotion, sale, and marketing of a drug for treating lupus. FEHBP health insurance carriers had paid more than $2.7 million for claims associated with this drug. After the scope of the investigation was narrowed to just violations of the Anti-Kickback Statute, we provided our claims data to the U.S. Department of Justice and closed our investigation.

- We received a *qui tam* filed in the U.S. District Court for the District of Massachusetts alleging that a medical provider entity attempted to improperly increase revenue by pressuring providers to add unsupported diagnosis codes, preparing diagnoses in patient charts prior to evaluation, pressuring providers to justify decisions declining to add diagnoses, using a retrospective chart review to identify areas where providers could be pressured to add diagnoses, and paying financial incentives and rewards to providers based on the volume and severity of diagnoses. FEHBP health insurance carriers paid $3.2 million to the medical provider entity. Due to the case being focused on violations of the Anti-Kickback Statute, we closed our investigation.

Retirement Oversight Activities

During FY 2023, OPM paid $104.7 billion in defined benefits to retirees, survivors, representative payees, and families under the CSRS and the FERS programs. This included $224.33 million in improper overpayments. The OPM OIG investigates allegations of fraud, waste, or abuse related to these overpayments.

In this reporting period, the OPM OIG and the OPM Retirement Services program office have worked together to improve OPM's process for referring potential fraud or improper payments detected by the OPM program office for investigation by the OIG.

We report multiple investigations during this 6-month period that involved losses to OPM of more than $500,000 and that occurred because monthly annuity or survivor annuity payments continued improperly for more than a decade. In many of our retirement investigations, the subjects of our investigation engage in deceitful behaviors (such as forging OPM Address Verification Letters) to hide that the rightful annuitant is deceased and to encourage OPM to continue disbursing annuity payments. Our investigative efforts to identify, stop, and recover these improper payments are essential to the integrity of OPM's retirement programs.

Nearly $1,000,000 in Survivor Annuity Payments Stolen

In April 2018, we opened an investigation after a CSRS survivor annuitant did not respond to OPM Address Verification Letters. Our investigation found that the annuitant had died in February 1988. In all, OPM sent more than $987,936 to the decedent after their death.

Our investigation identified the survivor annuitant's adult child as the person who had improperly taken the annuity payments. Their fraudulent actions included creating a joint bank account to redirect the CSRS survivor annuity payments after the survivor annuitant died.

In December 2019, the adult child pleaded guilty to theft of Government funds. However, the sentencing for this case was severely affected by delays related to the COVID-19 pandemic and numerous court postponements. Amid these delays and while awaiting sentencing, the adult child died. As a result, the criminal case was dismissed, and financial recovery was pursued through civil remedies. A probate case was opened in the U.S. District Court for the Northern District of Illinois. OPM received $176,355 from the estate of the adult child. OPM OIG's Office of Legal and Legislative Affairs and OPM's Office of General Counsel were also instrumental to the successful resolution of this case.

Indictment in Investigation of More Than 300 Post-Death Survivor Annuity Payments
In July 2023, we received a request for assistance from a Federal law enforcement partner in the investigation of a deceased CSRS survivor annuitant who died in January 1998. Our investigation found that the decedent's relative was listed on the death certificate. During our investigation, this person admitted to accessing the survivor annuity payments after the survivor annuitant's death. We found that OPM had stopped CSRS survivor annuity payments in July 2023 and dropped the case for death.

In all, OPM made more than 300 post-death annuity payments between January 1998 and June 2023, totaling $702,336. Treasury reclamation actions recovered $4,549, leaving a final loss to OPM of $697,787. Social Security Administration also issued post-death payments; in total, the Federal Government made more than $1 million in improper payments across all programs affected by this theft.

On December 19, 2023, a criminal complaint filed in the U.S. District Court for the District of New Jersey charged the relative with one count of wire fraud. Further judicial action related to this case is ongoing. This individual is presumed innocent unless or until guilt is established beyond a reasonable doubt in a court of law.

Representative Payee Pleads Guilty to Wire Fraud Related to Stealing Annuity Payments
An investigation into a representative payee who misused funds from multiple Government agencies, including OPM, ended in a guilty plea that will help OPM return annuity payments to the annuitant whose payments were stolen.

In March 2022, we received information from a Federal law enforcement partner about a Federal employee who allegedly stole annuity payments, including an OPM retirement annuity, from their parent—a retired Federal employee with dementia residing at a Veterans Affairs medical center in West Virginia. Our investigation found that the representative payee stole $81,001 intended for the retired Federal annuitant.

The representative payee made excessive cash withdrawals and allegedly altered bank statements as part of the theft.

In September 2023, the representative payee was indicted by a grand jury in the U.S. District Court for the Northern District of West Virginia on misappropriation by a fiduciary, wire fraud, theft of government property, false written statement, and false statements to Federal agents. The representative payee pleaded guilty to wire fraud on March 12, 2024. Further judicial action related to sentencing is anticipated in this case.

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 or contractors 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 OPM programs so that OPM employees, Federal employees, and the public can have faith in the integrity of OPM operations.

As 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.

Peer Review of the Railroad Retirement Board Office of Inspector General's Office of Investigations

During this semiannual reporting period, members of our Office of Investigations conducted a Council of the Inspectors General on Integrity and Efficiency (CIGIE) Peer Review of the Railroad Retirement Board (RRB) OIG Investigative Operations in conformity with the Quality Standards for Investigations and the Qualitative Assessment Review Guidelines established by CIGIE.

In our opinion, the system of internal safeguards and management procedures for the investigative function of the RRB OIG in effect for the November 6, 2017, to December 31, 2023, review period was in compliance with the quality standards established by CIGIE and other applicable guidelines and statutes.

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions authority (Title 5 United States Code (U.S.C.) § 8902a), we suspend or debar health care providers whose actions demonstrate that they are not sufficiently professionally responsible to participate in the FEHBP. At the end of the reporting period, there were a total of 39,169 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 517 administrative sanctions, including both suspensions and debarments, of health care providers who committed violations impacting the FEHBP and its enrollees. In addition, we addressed 2,022 sanctions-related inquiries and correspondence.

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 OPM OIG's Office of Investigations;
- Cases identified by the OPM OIG's ASG 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 their eligible family members.

The following cases handled during the reporting period highlight the importance of the work of the ASG.

Medical Practice Debarred Based on Control Interest Held by a Debarred Provider

In December 2019, our office debarred a provider based on his exclusion by the U.S. Department of Health and Human Services (HHS). Our debarment and his HHS exclusion remained in effect as of March 31, 2024.

During a previous reporting period, the Government Employees Health Association notified our office that they received a claim for services rendered by this debarred provider. 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 provider that his action was a violation of his debarment terms. We further informed the provider that should he continue to submit or cause the submission of FEHBP claims during his debarment period, these actions could be deemed violations of the Federal false claims statutes and potentially result in prosecution by a United States Attorney. Additionally, the provider was informed that such claims may be a basis for us to deny or delay future reinstatement into the FEHBP.

Under 5 U.S.C. § 8902a(c)(2)(d), OPM has the authority to debar an entity that is owned or controlled by a sanctioned provider. Additionally, Title 5 Code of Federal Regulations (CFR) § 890.1011(b) provides OPM authority to debar an entity that is owned or controlled by an individual who is currently debarred, suspended, or otherwise excluded from any procurement or non-procurement activity. OPM regulations at 5 CFR § 890.1003 define "control" as constituting the direct or indirect ownership of five percent or more of an entity or serving as an officer, director, agent, or employee of an entity. See 5 CFR § 890.1003.

The provider's violation prompted ASG staff to investigate the debarred provider's affiliated entities. The investigation identified a medical practice controlled by the debarred provider, which resulted in the issuance of a notice of proposed debarment to that practice. The medical practice responded to our proposed debarment, requesting that we rescind our action because the debarred provider divested his control over the practice. Evidence revealed that the debarred provider was no longer listed as an executive of the practice; however, the medical practice retained the physician to provide professional medical services despite knowledge of his HHS exclusion and OPM debarment. In addition, information obtained by ASG showed that the medical practice's National Provider Identifier (NPI) number is registered under the debarred provider's medical license. Based on the debarred provider's affiliation as an employee, his provision of professional medical services for the practice, and the medical practice's NPI registration under his medical license, we concluded the debarred provider maintained control over the practice.

The debarred provider's actions and affiliation with the medical practice posed a risk to FEHBP enrollees and the financial integrity of the program. The only factors that would warrant a decision to rescind the proposed debarment of the medical practice would be if the provider was no longer debarred or he no longer owned or held a control interest in the practice. The medical practice did not provide sufficient support for either of these factors. Therefore, the medical practice's request to rescind our proposed debarment was denied.

The debarment of the medical practice went into effect on October 30, 2023, and will coincide with the debarment terms of the debarred provider who holds ownership or control interest. The ASG identified and investigated this case.

Pennsylvania Laboratory Owner and Two Laboratories Debarred After Healthcare Fraud Conviction

In October 2023, our office debarred a laboratory owner who specialized in genetic testing after he was convicted in the United States District Court for the Western District of Pennsylvania for conspiracy to pay and receive kickbacks in connection with a Federal health care program (in this case, Medicare). The laboratory owner waived indictment and pleaded guilty to conspiring with others to pay illegal kickbacks for lab tests to companies he owned. In total, the laboratory owner and his co-conspirators filed $127 million in fraudulent claims in this wide-ranging, multi-State Medicare kickback scheme and received $60 million through their illegal activities.

The conspiracy involved two kinds of testing. One is called CGx, or cancer genomic testing, which uses deoxyribonucleic acid sequencing to detect mutations that could indicate cancer risk. The other is called PGx, or pharmacogenetic testing, which is designed to detect the effectiveness of medications.

He and others conspired to pay kickbacks to marketers, who in return obtained cheek swabs from Medicare beneficiaries at health fairs or through the mail to be used in lab tests. He also paid kickbacks to ensure that telemedicine doctors provided prescriptions for the lab tests for the swabs obtained by the marketers. His laboratories then billed Medicare for the tests, defrauding the United States healthcare system of $60 million.

He was sentenced to an 8-month prison term and ordered to pay more than $77 million in restitution and to forfeit a $9.1 million interest in property to the United States. In addition, our office issued a 5-year debarment to the laboratory owner individually—and to the two laboratories that he owned that were used to carry out the conspiracy. This case was referred to us by Blue Cross Blue Shield.

Missouri Internal Medicine Specialist and Clinic Debarred for Healthcare Fraud Conviction Involving Distribution of Controlled Substances

In March 2024, our office debarred an internal medicine physician after he was convicted in the United States District Court for the Western District of Missouri of health care fraud and the use of a Drug Enforcement Administration (DEA) registration number issued to another person in connection with the distribution of a controlled substance. According to court documents, from 2009 to 2019, the physician defrauded Medicare by allowing his employees, including receptionists, to fill prescriptions for controlled substances when he was not in the office and on several occasions when he was out of the country. The physician would sign prescriptions for controlled substances without actually seeing the patient and signed blank prescriptions for his employees to use in his absence. The employees then signed paperwork indicating to Medicare that the services had been provided by the physician. He and his staff repeatedly prescribed controlled substances outside the usual course of professional practice and without a legitimate medical purpose.

In May 2022, the physician pleaded guilty to health care fraud and admitted to submitting false information to Medicare on his treatment of patients and allowing his clinical and administrative staff to use his DEA registration number. He was sentenced to five years of probation and ordered to pay restitution in the amount of $19,261. We debarred both the physician and his clinic from the FEHBP for five years. This case was referred to us by Blue Cross and Blue Shield.

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 CIGIE. Office of Evaluations reports provide OPM management with findings and recommendations that assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

Evaluation of the U.S. Office of Personnel Management's Processing of Initial Retirement Claim Applications
Washington, D.C.
Report Number 2023-OEI-001
November 15, 2023

Our analyst completed an evaluation of OPM's Retirement Services processing of initial retirement claim applications. Retirement Services is responsible for the administration of the Federal Retirement Program covering nearly 2.8 million active employees, including the U.S. Postal Service, and more than 2.7 million annuitants, survivor annuitants, and eligible family members. Delays in processing initial retirement claim application packages for Federal employees have been a long-standing problem. As a result, we sought to determine (1) what progress Retirement Services has made in improving the timeliness of initial retirement claims processing since the Government Accountability Office (GAO) report (see below) and (2) what obstacles Retirement Services continues to face in meeting its timeliness and inventory goals for processing initial retirement claim applications.

In May 2019, GAO issued a report titled, *Federal Retirement: OPM Actions Needed to Improve Application Processing Times* (GAO-19-217). In this report, OPM identified three main causes of the continued delays in retirement application processing: (1) reliance on a paper-based application, (2) insufficient staffing, and (3) incomplete applications. The GAO report focused on analyzing these root causes and issued six recommendations addressing the retirement application processing delays.

During our evaluation, we determined that:

- Improvements are needed regarding Retirement Services' monthly Agency Audit Report;
- Improved transparency is needed in reporting application processing times; and
- Five of the six GAO recommendations remain open.

We made five recommendations to improve Retirement Services' operations in the handling of initial retirement claim applications. Retirement Services' management generally concurred with our recommendations and indicated its corrective action plans.

Legal and Legislative Activities

Under the Inspector General Act of 1978, as amended (5 U.S.C. Chapter 4), OIGs are required to obtain legal advice from a counsel reporting directly to an IG. This reporting relationship ensures that the OIG receives independent and objective legal advice. The OPM OIG Office of Legal and Legislative Affairs discharges this statutory responsibility in several ways, including by providing advice to the immediate OIG 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 IG and other OIG components on many legal and regulatory matters. The office also evaluated proposed legislation related to both OPM and OIG programs and operations. As part of these activities, we tracked and provided comments on proposed and draft legislation to both Congress and the CIGIE Legislation Committee.

Congressional Inquiries and Requests

The office participated in eight distinct engagements with interested Congressional stakeholders since our last semiannual report. We worked with other OIG components to field questions, provide responses, or coordinate briefings to address specific Congressional requests and inquiries that covered a range of topics, including OPM's implementation of the PSHBP, Retirement Services, open audit recommendations, agency telework policies and practices, and whistleblower protections.

PSHBP Implementation Oversight

During a meeting with Congressional appropriators to discuss the OIG's oversight of OPM's PSHBP implementation, we had the opportunity to highlight specific results from our ongoing reviews, demonstrate the value and importance of strong, real-time oversight, and emphasize the importance of adequate funding to support our efforts. As we have previously communicated in our recent semiannual reports, the OPM OIG remains committed to conducting active reviews of the PSHBP implementation, in order to identify and communicate weaknesses or issues to OPM for remediation in a timely manner.

Anti-Kickback Statute Exclusion

The office also continued to share our concerns about the FEHBP's continued exclusion from the Federal Anti-Kickback Statute with Congressional stakeholders. When it launches on January 1, 2025, the PSHBP will immediately be vulnerable to the same risk of fraud from kickbacks as the FEHBP is currently. The FEHBP's exclusion from the Anti-Kickback Statute hampers the OIG's ability to detect, investigate, and obtain restitution regarding kickbacks that occur within the FEHBP. This results in an estimated annual loss of tens of millions of dollars to the FEHBP Trust Fund and leaves FEHBP members exposed to potential harm from medically unnecessary treatments.

Statistical Summary of Enforcement Activities

Investigative Actions and Recoveries:

Indictments and Criminal Informations	8
Arrests	7
Convictions	5
Criminal Complaints/Pre-Trial Diversion	1
Subjects Presented for Prosecution	27
Federal Venue	27
Criminal	14
Civil	13
State Venue	0
Local Venue	0
No-Knock Entries[1]	0
No-Knock Entries Pursuant to Judicial Authorization	0
No-Knock Entries Pursuant to Exigent Circumstances	0
No-Knock Entries in which Law Enforcement Officer or Other Person was Injured	0
Dollars Presented to the U.S. Department of Justice[2]	$155,631,623
Expected Recovery Amount to OPM Programs	$1,545,750
Civil Judgments and Settlements	$1,323,157
Criminal Recoveries	$94,000
Administrative Recoveries	$128,593
Expected Recovery Amount for All Programs and Victims[3]	$44,875,794
Criminal Fines, Penalties, Assessments, and Forfeitures	$13,900

1 This information is reported as part of the reporting required by Executive Order 14074, Accountable Policing and Criminal Justice Practices to Enhance Public Trust and Public Safety, Section 10(c).

2 The "Dollars Presented to the U.S. Department of Justice" is a new metric presented during this semiannual reporting period to quantify OPM OIG's investigative efforts. Not all cases that the OPM OIG expends investigative resources on are accepted for prosecution—sometimes because of program issues (such as the Anti-Kickback Statute excluding the FEHBP), sometimes because of competing priorities for the limited prosecutive resources of U.S. Attorney's Offices, and sometimes for other reasons. This statistic attempts to better present how OPM programs are affected by potential improper payments due to fraud, waste, or abuse.

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

Investigative Administrative Actions:

FY 2024 Investigative Reports Issued[4]	77
Issued between October 1, 2023, and March 31, 2024	77
Whistleblower Retaliation Allegations Substantiated	0
Cases Referred for Suspension and Debarment	8
Personnel Suspensions, Terminations, or Resignations	0
Referrals to the OPM OIG Office of Audits	0
Referrals to an OPM Program Office	3

Administrative Sanctions Activities:

FEHBP Debarments and Suspensions Issued	517
FEHBP Provider Debarment and Suspension Inquiries	2,022
FEHBP Debarments and Suspensions in Effect at the End of the Reporting Period	39,169

Table of Enforcement Activities

Cases Opened	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations[5]	25	2	0	3	30
Preliminary Investigations[6]	60	7	0	5	72
FEHBP Carrier Notifications/Program Office	722	8	0	1	731
Complaints – All Other Sources/Proactive[7]	196	11	0	7	214

Cases Closed	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	29	9	0	0	38
Preliminary Investigations	21	0	0	0	21
FEHBP Carrier Notifications/Program Office	631	4	0	0	635
Complaints – All Other Sources/Proactive	154	5	0	3	162

Cases In-Progress[8]	Healthcare & Insurance	Retirement Services	Other OPM Program Offices	External/ Internal Matters	Total
Investigations	119	19	0	5	143
Preliminary Investigations	42	9	0	3	54
FEHBP Carrier Notifications/Program Office	184	2	0	1	187
Complaints – All Other Sources/Proactive	36	3	0	0	39

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

OIG Hotline Complaint Activity

OIG Hotline Complaints Received	1,918
Sources of OIG Hotline Cases Received	
Website	1,025
Telephone	682
Letter	129
Email	79
Other	3
OPM Program Office	
Healthcare and Insurance	**456**
Customer Service	50
Healthcare Fraud, Waste, and Abuse Complaint	228
Other Healthcare and Insurance Issues	178
Retirement Services	**770**
Customer Service	348
Retirement Fraud, Waste, and Abuse Complaint	118
Other Retirement Services Issues	304
Other OPM Program Offices/Internal Matters	**27**
Customer Service	2
Other OPM Program Fraud, Waste, and Abuse	5
Other OPM Program Issue	20
External Agency Issue (unrelated to OPM)	**665**
OIG Hotline Complaints Reviewed and Closed[9]	1,745
Outcome of OIG Hotline Complaints Closed	
Referred to External Agency	**31**
Referred to OPM Program Office	**464**
Retirement Services	317
Healthcare and Insurance	105
Other OPM Programs/Internal Matters	42
Referred to FEHBP Carrier	**90**
No Further Action	**1,157**
Converted to Case	**3**
OIG Hotline Complaints Pending Review	309
By OPM Program Office	
Healthcare and Insurance	93
Retirement Services	187
Other OPM Program Offices/Internal Matters	5
External Agency Issue (unrelated to OPM)	4
To be determined	20

9 Includes hotline cases that may have been received in a previous reporting period.

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Appendices

Appendix I-A

Final Reports Issued With Questioned Costs for Insurance Programs

October 1, 2023, to March 31, 2024

Subject		Number of Reports	Questioned Costs
A.	Reports for which no management decision had been made by the beginning of the reporting period	10	$50,276,979
B.	Reports issued during the reporting period with questioned costs	5	$305,690,281[1]
	Subtotals (A+B)	15	$355,967,260
C.	Reports for which a management decision was made during the reporting period:	1	$33,734,081
	1. Net disallowed costs	N/A	$33,349,534
	Disallowed costs during the reporting period	N/A	$33,535,304[2]
	Less: costs originally disallowed but subsequently allowed during the reporting period	N/A	$185,770[3]
	2. Net allowed costs	N/A	$384,547
	Allowed costs during the reporting period	N/A	$198,777[4]
	Plus: costs originally disallowed but subsequently allowed during the reporting period	N/A	$185,770[3]
D.	Reports for which no management decision has been made by the end of the reporting period	14	$322,233,179
E.	Reports for which no management decision has been made within 6 months of issuance	10	$73,035,423

1 Includes $53,675,565 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

October 1, 2023, to March 31, 2024

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:	1	$164,212
	1. Net disallowed costs	N/A	$0
	2. Net allowed costs	N/A	$164,212
D.	Reports for which no management decision has been made by the end of the reporting period	0	$0
E.	Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix II

Resolution of Questioned Costs in Final Reports for Insurance Programs

October 1, 2023, to March 31, 2024

Subject		Questioned Costs
A.	Value of open recommendations at the beginning of the reporting period	$50,276,979
B.	Value of new audit recommendations issued during the reporting period	$305,690,281[1]
	Subtotals (A+B)	$355,967,260
C.	Amounts recovered during the reporting period	$33,349,534
D.	Amounts allowed during the reporting period	$384,547
E.	Other adjustments	$0
	Subtotals (C+D+E)	$33,734,081
F.	Value of open recommendations at the end of the reporting period	$322,233,179

1 Includes $53,675,565 in additional questioned costs from a report that was previously issued.

Appendix III

Final Reports Issued with Recommendations for Better Use of Funds

October 1, 2023, to March 31, 2024

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:	1	$6,140,755
D.	Reports for which no management decision has been made by the end of the reporting period	0	$0
E.	Reports for which no management decision has been made within 6 months of issuance	0	$0

Appendix IV

Insurance Audit Reports Issued

October 1, 2023, to March 31, 2024

Report Number	Subject	Date Issued	Questioned Costs
2022-CRAG-037	UnitedHealthcare Insurance Company, Inc. in Minnetonka, Minnesota	October 30, 2023	$0
2023-CAAG-001	Claims Processing and Payment Operations at Select Anthem Blue Cross and Blue Shield Plan Sites for Contract Years 2019 through 2021 in Washington, D.C.	November 7, 2023	$203,698,855
2023-CRAG-011	Dean Health Plan in Madison, Wisconsin	January 12, 2024	$0
2023-CAAG-009	Claims Processing and Payment Operations at all Blue Cross and Blue Shield Plans as Related to Provider Network Status for Contract Years 2019 through 2021 in Washington, D.C.	February 15, 2024	$1,038,050
2023-ERAG-004	BlueCross BlueShield of South Carolina in Columbia, South Carolina	February 20, 2024	$43,461
2023-CAAG-020	FEHBP Claims Processing and Payment Operations as Administered by Regence for Contract Years 2019 through 2021 in Tacoma, Washington	February 20, 2024	$0
2023-ERAG-005	Blue Cross Blue Shield of North Carolina in Durham, North Carolina	February 26, 2024	$954,142
2023-CAAG-022	Claims Processing and Payment Operations as Administered by Blue Cross and Blue Shield of Florida for Contract Years 2020 through 2022 in Jacksonville, Florida	March 6, 2024	$0
2023-CRAG-010	Blue Care Network of Michigan in Detroit, Michigan	March 12, 2024	$0
2022-SAG-029	American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021 in Glen Burnie, Maryland	March 29, 2024	$46,280,208
TOTAL			$252,014,716

Appendix V

Internal Audit Reports Issued

October 1, 2023, to March 31, 2024

Report Number	Subject	Date Issued
2023-IAG-017	The U.S. Office of Personnel Management's Fiscal Year 2023 Consolidated Financial Statements in Washington, D.C.	November 13, 2023
2022-CAAG-001	The U.S. Office of Personnel Management's Disputed Claims Process for years 2018 through 2020 in Washington, D.C.	December 20, 2023
2023-IAG-008	The U.S. Office of Personnel Management's Purchase Card Program in Washington, D.C.	February 20, 2024

Appendix VI

Information Systems Audit Reports Issued

October 1, 2023, to March 31, 2024

Report Number	Subject	Date Issued
2022-ISAG-040	Information Systems General and Application Controls at Blue Cross Blue Shield of South Carolina in Columbia, South Carolina	October 11, 2023
2023-ISAG-006	Federal Information Security Modernization Act Audit - Fiscal Year 2023 in Washington, D.C.	November 22, 2023
2023-ISAG-016	Information Technology Security Controls of the U.S. Office of Personnel Management's Enterprise Mainframe System in Washington, D.C.	February 26, 2024

Appendix VII

Postal Service Health Benefits Program Audit Reports Issued

October 1, 2023, to March 31, 2024

Report Number	Subject	Date Issued
PSHB-084	The U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Project Management in Washington, D.C.	November 2, 2023
PSHB-085	Flash Audit Alert – The U.S. Office of Personnel Management's Implementation of the Postal Service Health Benefits Program: Carrier Connect Authorization to Operate in Washington, D.C.	November 15, 2023

Appendix VIII

Evaluation Reports Issued

October 1, 2023, to March 31, 2024

Report Number	Subject	Date Issued
2023-OEI-001	Evaluation of the U.S. Office of Personnel Management's Processing of Initial Retirement Claim Applications in Washington, D.C.	November 15, 2023

Appendix IX

Summary of Reports More Than Six Months Old Pending Corrective Action

As of March 31, 2024

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
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-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	2	0	7
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-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-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-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	3	0	5
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	9	0	19

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-CI-00-17-014	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017	1	0	4
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-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	11	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	10	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-CF-00-16-055	The U.S. Office of Personnel Management's Common Services in Washington, D.C.	March 29, 2018	2	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-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	11	0	23
4K-CI-00-18-009	The U.S. Office of Personnel Management's Preservation of Electronic Records in Washington, D.C.	December 21, 2018	1	0	3

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
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
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	3	0	23
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	11	0	20
1H-01-00-18-039	Management Advisory Report - Federal Employees Health Benefits Program Prescription Drug Benefit Costs in Washington, D.C.	February 27, 2020 Reissued March 31, 2020	2	0	2
4A-RS-00-18-035	The U.S. Office of Personnel Management's Federal Employees Health Benefits Program and Retirement Services Improper Payments Rate Methodologies in Washington, D.C.	April 2, 2020	4	6	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-CI-00-20-009	The U.S. Office of Personnel Management's Security Assessment and Authorization Methodology in Washington, D.C.	September 18, 2020	1	0	11

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
4A-HI-00-19-007	The U.S. Office of Personnel Management's Administration of Federal Employee Insurance Programs in Washington, D.C.	October 30, 2020	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-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	11	0	21
1C-GG-00-20-026	Information Systems General Controls at Geisinger Health Plan in Danville, Pennsylvania	March 9, 2021	0	1	2
4A-HI-00-18-026	Management Advisory Report - FEHB Program Integrity Risks Due to Contractual Vulnerabilities in Washington, D.C.	April 1, 2021	11	0	11
4A-CF-00-21-008	The U.S. Office of Personnel Management's Fiscal Year 2020 Improper Payments Reporting in Washington, D.C.	May 17, 2021	1	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
4A-CI-00-20-034	The U.S. Office of Personnel Management's Office of the Chief Information Officer's Revolving Fund Programs in Washington, D.C.	September 9, 2021 Reissued November 22,2021	1	0	4
4A-CI-00-21-012	Federal Information Security Modernization Act Audit Fiscal Year 2021 in Washington, D.C.	October 27, 2021	1	0	36
4A-CF-00-21-027	The U.S. Office of Personnel Management's Fiscal Year 2021 Consolidated Financial Statements in Washington, D.C.	November 12, 2021	11	0	20
4A-CF-00-20-029	The U.S. Office of Personnel Management's Utilization of the Improper Payments Do Not Pay Initiative in Washington, D.C.	February 14, 2022	1	0	7

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
1A-10-17-21-018	Health Care Service Corporation for Contract Years 2018 through 2020 in Chicago, Illinois	February 23, 2022 Reissued March 16, 2022	3	1	18
N/A	Review of the 2017 Presidential Management Fellows Program Application Process Redesign in Washington, D.C.	May 18, 2022	8	0	8
2022-IAG-002	The U.S. Office of Personnel Management's Compliance with the Payment Integrity Information Act of 2019 in Washington, D.C.	June 23, 2022	2	0	6
1C-59-00-20-043	Kaiser Foundation Health Plan, Inc. in Oakland, California	August 16, 2022	1	0	16
1A-10-15-21-023	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee	August 25, 2022	1	0	11
1G-LT-00-21-013	Federal Long Term Care Insurance Program for Contract Years 2017 through 2019 in Portsmouth, New Hampshire	September 12, 2022	1	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	11	0	15
2022-ISAG-0017	Federal Information Security Modernization Act Audit - Fiscal Year 2022 in Washington, D.C.	November 15, 2022	1	0	29
2022-ERAG-0011	Premera BlueCross in Mountlake Terrace, Washington	December 12, 2022	1	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	2	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	3	0	6

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
2022-CRAG-0010	The Federal Employees Health Benefits Program Termination Process at Health Plan of Nevada, Inc. in Las Vegas, Nevada	February 15, 2023	3	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	1	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	2	0	5
2022-CAAG-0014	Evaluation of COVID-19's Impact on FEHBP 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	0	3	5
2022-IAG-0016	The U.S. Office of Personnel Management's Travel Charge Card Program in Washington, D.C.	April 18, 2023	11	3	21
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	2	0	2
2022-IAG-0019	The U.S. Office of Personnel Management's Retirement Services' Settlement Process in Washington, D.C.	June 15, 2023	0	5	5

Appendix IX *continued*

Report Number	Subject	Date Issued	Recommendations		
			Open Unresolved	Open Resolved[1]	Total
2022-CAAG-035	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	11	0	11
2022-ISAG-036	Information Systems General and Application Controls at Health Alliance Medical Plans, Inc. in Champaign, Illinois	July 13, 2023	0	13	17
2023-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	12	0	16
2023-ISAG-003	Information Systems General and Application Controls at Blue Cross of Idaho in Meridian, Idaho	August 10, 2023	0	2	7
2022-ERAG-0022	Blue Shield of California Access+ HMO in Oakland, California	August 21, 2023	0	1	19
2022-CRAG-032	Medical Mutual of Ohio in Cleveland, Ohio	August 21, 2023	0	1	20
TOTAL			236	47	713

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

Appendix X

Most Recent Peer Review Results

As of March 31, 2024

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

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

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

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

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

Appendix XI

Investigative Recoveries

October 1, 2023, to March 31, 2024

Investigative Recovery Area	Sum of Total Recovery Amount	Sum of OPM Recovery Net
Administrative Action	$172,438	$128,593
Retirement Services	$172,438	$128,593
CSRS & FERS	$172,438	$128,593
Administrative Debt Recovery	$92,078	$92,078
Referral	$80,360	$36,515
Civil Action	$44,609,355	$1,323,157
Healthcare and Insurance	$44,432,999	$1,152,092
Federal Employees Health Benefits Program (FEHBP)	$44,432,999	$1,152,092
Civil Action	$44,432,999	$1,152,092
Retirement Services	$176,355	$171,064
CSRS & FERS	$176,355	$171,064
Civil Action	$176,355	$171,064
Criminal Action	$94,000	$94,000
Retirement Services	$94,000	$94,000
CSRS & FERS	$94,000	$94,000
Criminal Judgement/Restitution	$94,000	$94,000
Grand Total	$44,875,794	$1,545,750

Index of Reporting Requirements

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

Requirement		Page
1	Review of legislation and regulations	36
2	Significant problems, abuses, and deficiencies as well as the associated reports and recommendations for corrective action	6–22; 35
3	Recommendations made before the reporting period, for which corrective action has not been completed	OIG's Website
4	Significant investigations closed during the reporting period	38
5	Number of convictions closed during the reporting period resulting from investigations	37–39
6	Audit, inspection and evaluation reports issued during the reporting period, including information regarding the value of questioned costs and recommendations for funds put to better use	42–50
7	Management decisions made during the reporting period with respect to audits, inspections, and evaluations issued during a previous reporting period	51–57
8	Reportable information under section 804(b) of the Federal Financial Management Improvement Act of 1996	15–16; 18–22
9	Information pertaining to peer review by other OIGs	58
10	Statistical tables showing the number of: investigative reports issued, persons referred for criminal prosecution, and indictments and criminal informations during the reporting period	37–39; 59
11	Metrics used for developing the data for the table showing investigative reports, persons referred for criminal prosecution, and indictments and criminal informations	37–39
12	Reports on investigations involving substantiated misconduct by senior Government employees or officials	No Activity
13	Descriptions of whistleblower retaliation, including implicated individuals and any consequences imposed	No Activity
14	Agency attempts to interfere with OIG independence	No Activity
15	Closed investigations, audits, and evaluations not disclosed to the public	37–39
16	Closed investigations involving senior Government employees, not disclosed to the public	No Activity

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

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