United States
Office of
Personnel Management
The Federal Government's Chief Human Resources Agency

2026 FEHB and PSHB Programs Financial Reporting and Audit Guide

Federal Employees Health Benefits (FEHB) Program

Postal Service Health Benefits (PSHB) Program

For the Carriers of Experience-Rated Plans
and their Independent Public Accountants

March 2026

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Chapter I, Purpose and Authority

Purpose of this Guide

The U.S. Office of Personnel Management (OPM) has issued this 2026 FEHB and PSHB Programs Financial Reporting and Audit Guide ("Guide"). The purpose of the Guide is to:

- Obtain financial information pertaining to the Federal Employees Health Benefits (FEHB) Program and Postal Service Health Benefits (PSHB) Program ("Program") that has been subjected to audit procedures.
- Obtain assurance that Carriers of experience-rated plans submit financial statements that are fairly stated in all material respects, prepared, and audited in accordance with prescribed guidelines.
- Validate whether or not any Carrier has conducted their Program-related operations in accordance with their contract with OPM.
- Support a nationwide estimate of the improper payments and unknown payments made by the Carriers, as required by the Office of Management and Budget Circulars A-123, Appendix C and A-136, Financial Reporting Requirements.

Since OPM must periodically revise its financial and auditing requirements, inconsistencies may exist at any given time between the Guide and other OPM guidelines. It is the Carrier's responsibility to ensure that it and its agents are applying the most current guidelines.

OPM Authority and Carrier Responsibilities

Standard Program Contract:

Section 3.2 - Accounting and Allowable Cost - each Carrier must furnish to OPM an accounting of its operations under the contract. In preparing this accounting, the Carrier must follow the reporting requirements and statement formats prescribed by OPM in this Guide. In addition, the Carrier must have its annual accounting statements audited in accordance with this Guide.

- Section 3.10 - Audit, Financial, and Other Information - requires that each Carrier furnish to OPM audit, financial, and other information in the format and within the timeframes specified in this Guide.

OPM Healthcare and Insurance requires those approved Carriers in the FEHB Plan to have annual accounting statement standards that are recognized as best practices, are accurate, and that maximize consistency and transparency.

OPM Healthcare and Insurance retains the right to require Carriers to produce and deliver to OPM any financial information, payment evidence, accounting report or ledger, auditor records, supporting documents, any contract, any work papers, any or all price or cost information including but limited to markups, economic information, claims data elements, bank account records, tax statements and returns, State tax information, reinsurance information, asset or liability transfer or sale detail, corporate governance information, legal or regulatory filing, litigation documents and filings, payroll records, employment records, any agreements between the Carrier and its affiliates, any agreements between the Carrier and Medicare or State Medicare Administrators, and any agreements between the Carrier and pharmaceutical manufacturers or pharmacy intermediaries or other records and information (the foregoing referred to as "Financial Information"). This Financial Information may be either the same or different from the items listed below in this Audit Guide. This Audit Guide specifically requires the Carriers to make available to OPM Healthcare and Insurance, any and all Financial Information requested by OPM Healthcare and Insurance rather than only those items listed in the Audit Procedures included herein. Any reference herein to Agreed Upon Procedures does not limit OPM in requesting and receiving any Financial Information.

Chapter II, Overview of Reporting and Auditing Requirements

A. Financial Reporting

All Carriers must prepare and submit to the OPM the following financial statements and schedules:

1. GAAP FINANCIAL STATEMENTS: The Carrier must fully adopt and comply in all material respects with U.S. Generally Accepted Accounting Principles ("US GAAP") for its financial statements beginning in 2026. For those Carriers that are subsidiaries of or affiliated with entities that have issued registered securities in the United States, the Carrier must also have auditors that comply with the Public Company Accounting Oversight Board ("PCAOB"). Carriers shall in 2026 prepare and deliver to OPM GAAP interim consolidated and annual consolidated and consolidating financial statements for the Carrier and their affiliates. Unaudited financial statements are due 30 days after the end of interim dates March 31 and September 30 and 45 days after calendar year-end December 31. Interim and Annual financial statements must be submitted to OPM along with the opinion of the Carrier's independent auditor that the financial statements are fairly presented in all material respects and that there are no material weaknesses nor significant deficiencies. The financial statements must reflect the assets of the Carrier and not those that are owned by the FEHB Plan. The financial statements must include footnotes, management discussion and analysis, and the Health Benefits Paid Schedule listed in number 2 below. There will be a transition period during 2026, during which the Statements of Selected Balances will be required to be prepared and delivered to OPM Healthcare and Insurance ("HI") Associate Director ("AD") concurrently for the remainder of fiscal 2026 until they are retired October 1, 2026. Carrier financial statements in 2026 must include GAAP comparative prior period disclosure.
2. HEALTH SERVICE USE, HOSPITAL, AND DRUG CODE SCHEDULE: Interim and Annual financial statements for Carriers must include a schedule of service use and cost data for medical, hospital, drugs and any other health benefit expense for the period and for comparable prior periods listing in detail the aggregate of each health service medical, hospital and drug benefit expense by medical diagnosis and treatment code, hospital code, J code, and NDC drug code. In addition, this Health Service Use, Hospital, and Drug Code Schedule must include the provider numbers to which the service use, medical, hospital, drug, and any other health benefit expense that is paid by FEHB Plan to the Carrier relate. These coded amounts along with provider numbers must reconcile to the claim amounts submitted to OPM by the Carrier for Letter of Credit Account Authorizations. The Statement of Selected

Balances is retired for fiscal 2027 and is replaced by the GAAP March, September, and December financial statements.

FAR 31.201-5 provides that the applicable portion of any income, rebate, allowance, or other credit relating to any allowable cost and received by or accruing to the contractor shall be credited to the government either as a cost reduction or by cash refund. Program credits result from benefit payments that include, but are not limited to:

a. Coordination of benefit refunds
b. Hospital year-end settlements
c. Uncashed and returned checks
d. Utilization review refunds
e. Refunds attributable to litigation with subscribers or providers of health services
f. Erroneous benefit payment, overpayment, and duplicate payment recoveries (48 CFR 1631.201-70).

3. Taxes: Except as limited by 5 U.S.C. 8909(f)(2), 5 U.S.C. 8909(f)(1) prohibits the imposition of taxes, fees, or other monetary payment, directly or indirectly, on Program premiums by any state, the District of Columbia, or the Commonwealth of Puerto Rico or by any political subdivision or other governmental authority of those entities. (48 CFR 1631.205-41)
4. Commingling of Program Funds: Program funds shall be maintained separately from other cash and investments of the Carrier or underwriter. (48 CFR 1632.771). Carrier or underwriter commingling of Program funds with those from other sources makes it difficult to precisely determine Program cash balances at any given time or to precisely determine investment income attributable to Program invested assets. Carriers shall not claim any Program funds as their own and therefore are precluded from commingling Program funds with those of other sources. Any waivers by contracting officers referred to in 48 CFR 1632.771 are hereby rescinded.

B. Management Internal Controls (All Carriers)

OPM has been directed by OMB, via OMB Circular No A-123, Management's Responsibility for Enterprise Risk Management and Internal Control, to establish and maintain internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations.

To accommodate this requirement, Carriers are required to provide OPM with a letter documenting their internal controls. The letter must inform OPM of any material weaknesses/significant deficiencies for Federal FY 2026, October 1, 2025, through September 30, 2026, and/or any significant subsequent events for the overall period of October 1, 2025, through September 30, 2026. In addition, Carriers are required to submit their letter for the Federal FY 2026 no later than 5:00pm ET on October 15, 2026.

The letter must be addressed to OPM's Associate Director of Healthcare & Insurance and OPM's Chief Financial Officer submitted in an email. The email addresses for submitting the Management Internal Controls are Ins-Carriers@opm.gov (FEHB), OCFO-PSHB@opm.gov (PSHB), and FEHBIP@opm.gov (FEHB and PSHB), using "Management Internal Controls – (Plan Name) and (Contract Number)" as the subject line.

C. Application Of Improper Payments Reporting Agreed-Upon Procedures (All Carriers)

OPM requires that all Experience-Rated Carriers require their IPAs to perform agreed-upon procedures(AUPs), to provide OPM with assurance that Program operations are being performed in accordance with regulations and the Carrier contracts. Carriers are required to conduct one AUP per contract that covers the plan codes for that contract. The procedures required are provided in Appendix D. OPM will not consider alternate procedures designed to produce similar results.

The required reporting deliverables on the application of agreed-upon procedures are due to OPM by:

- **March 31, 2027**, for Carriers who selected Financial Reporting Option 1 under the 2025 Financial Reporting and Audit Guide, and should cover the period from January 1, 2026 through December 31, 2026. Carriers reporting of this time period will be called "Calendar Year AUP Reporters" in this document.
- **December 15, 2026**, for Carriers who selected Financial Reporting Option 2 under the 2025 Financial Reporting and Audit Guide, and should cover the period from October 1, 2025 through September 30, 2026. Carriers reporting of this time period will be called "Fiscal Year AUP Reporters" in this document.

The AUP reporting deliverables include:

- OPM AUP Reports Spreadsheet with the following tabs filled out:
    - IPs Defined by Activity
    - AUP Test Results Table
    - Table 6 –Avg Days to Pay Claims
    - Table 7 – Letter of Credit Authorizations
    - Current and Prior Year's Findings
- Attestation and Formal Written Report
    - Appendix E – Sample IPA Reports
        - Report on Agreed Upon Procedures

Carriers sampling twice per year will have one submission (based on financial reporting option selected) with two separate sets of OPM AUP Reports Spreadsheets. They will submit only one attestation/formal written report which must contain a separate set of tables for each sampling period.

All Experience-Rated Carriers must submit their OPM AUP Reports spreadsheet(s) to the following email addresses:

- FEHBIP@opm.gov (FEHB and PSHB), with a copy to their OPM Contracting Officer,
- Ins-Carriers@opm.gov (FEHB),

  or

- OCFO-PSHB@opm.gov (PSHB).

Please use the email subject line, "AUP Reports – (Plan Name) and (Contract Number)."

D. Corrective Action Plans

To ensure that deficiencies discovered during the performance of the Improper Payment Reporting Agreed Upon Procedures are resolved, all Carriers must develop and submit to OPM a Corrective Action Plan (CAP).

A CAP, if applicable, is due to OPM by:

- **June 30, 2027,** for Calendar Year AUP Reporters.
- **March 15, 2027,** for Fiscal Year AUP Reporters.

The CAP is an essential part of a Carrier's annual reporting requirements. It must be presented on the Carrier's letterhead, signed by an appropriate Carrier official, and include their title and telephone number.

The CAP must:

- Describe the corrective action taken or planned in response to findings identified in the IPA's report.
- Include a narrative describing the current status of the corrective action taken on any findings included in the IPA's two prior reports.

The CAPs must be sent to the following email addresses:

- FEHBIP@opm.gov (FEHB and PSHB), with a copy to their OPM Contracting Officer,
- Ins-Carriers@opm.gov (FEHB),

  or

- OCFO-PSHB@opm.gov (PSHB).

Please use the email subject line, "CAP Report – (Plan Name) and (Contract Number)."

Appendix A. Freedom of Information Act Requests

Notification to Submitters of Confidential Commercial Information

You have been or may be asked to submit information to the Office of Inspector General (OIG), U.S. Office of Personnel Management in connection with these procedures, audit, inspection or other inquiry pursuant to the Inspector General Act of 1978, as amended,

5 U.S.C. app. 3, sec. 1 et seq. This is to notify you that if you deem any of this information to be "confidential commercial information," you may take steps to so designate that information to protect its confidentiality if at a future point in time a request is made for disclosure of this information under the Freedom of Information Act (FOIA).

"Confidential commercial information" means records that may contain material exempt from release under Exemption 4 of FOIA (pertaining to trade secrets and commercial or financial information that is privileged or confidential), because disclosure could reasonably be expected to cause substantial competitive harm.

You may use any reasonable method you believe appropriate, and which is acceptable to the OIG, to indicate which documents and information you deem to fall into the category of "confidential commercial information." Please be as specific as possible in segregating the information that you consider to be "confidential commercial information" from any other information you are providing to the OIG. This may be done before such information is provided to the OIG if feasible, but only if it will not delay or interfere with production of the information or delay or interfere with the OIG's investigation, audit, inspection, or other inquiry. Otherwise, you may so designate this information within a reasonable period after the information is provided to the OIG.

If a FOIA request is received by the OIG for information you have designated as "confidential commercial information," the OIG is nevertheless required by law to make its own independent determination of whether the FOIA requires disclosure of the information or whether it should be withheld pursuant to Exemption (b)(4) or any other exemption of FOIA. If the OIG determines that it may be required to disclose, pursuant to FOIA, that information you have designated or other information that the OIG has reason to believe could be expected to cause substantial competitive harm, to the extent permitted by law, we will make a good faith effort to notify you and provide you with a reasonable opportunity to object to such disclosure and to state all grounds upon which you oppose disclosure. We will consider all specified grounds for nondisclosure prior to making our final decision.

If we nonetheless believe that disclosure is required, we will provide you with a statement explaining why your objections were not sustained and specifying a disclosure date. To the extent permitted by law, this statement will be provided to you within a reasonable number of days prior to the specified disclosure date. Furthermore, if disclosure of the designated information is denied pursuant to an exemption under FOIA and an administrative or judicial appeal is taken by the FOIA requester, we will make a good faith effort to notify you promptly.

The procedures outlined in this notice are intended only to improve the internal management of the OIG and are not intended to create any right or benefit, substantive or procedural, enforceable at law by a party against the United States, its agencies, officers, or any person.

Appendix B. Management Internal Controls Letter for All Carriers

To accompany each audited annual financial statement:

Letter of the Carrier's Management Internal Controls to United States Office of Personnel Management (OPM):

Carrier provides to OPM these representations and warranties with respect to the Carrier management's acknowledgement of its responsibility; completeness of information; representations related to fraud, and management's responsibility for the design, implementation, and maintenance of internal control to prevent and detect fraud; compliance with laws and regulations, contracts and grant agreements; that all amounts of rebates, volume discounts, price incentives, and any other type of economic benefit that is in any way related to healthcare claim costs have been properly accounted by the Carrier and applied by the Carrier on a cash or accrual basis to offset Carrier healthcare costs that result in claims made against the United States. All such economic Items are considered material, regardless of size, if they involve an omission or misstatement of accounting information that, in the light of surrounding circumstances, makes it probable that the judgment of a reasonable person relying on the information would be changed or influenced by the omission or misstatement.

Except where otherwise stated below, immaterial individual accounting items less than $50,000 or all accounting items collectively of less than $200,000 are not considered to be exceptions that require disclosure for the purpose of the following representations.

Notwithstanding the representations and warranties above, Carrier management and its outside auditors must, to the best of our knowledge and belief, make such inquiries as we considered necessary for the purpose of appropriately informing ourselves, as of September 30, 2026, the following representations:

1. Carriers' responsibilities are not limited by the terms of this 2026 FEHB and PSHB Programs Financial Reporting and Audit Guide,

2. Carriers must disclose all accounting policies and practices adopted that, if applied to significant items or transactions, would not be in accordance with U.S. GAAP. Carriers must evaluate the impact of the application of each such policy and practice, both individually and in the aggregate, on the financial statements and the expected impact of each such policy and practice on future periods' financial reporting and represent that the effect of these policies and practices on the financial statements is not material. In addition, Carriers must represent that the impact of the application of these policies and practices will not be material to the financial statements in future periods.

3. There are no restatements or changes in accounting principles that affect the consistency of the financial statements between periods.

OPM reserves the right to receive from the Carriers any or all of the following information:

a. All records, documentation, and information that is relevant to the preparation of the Carrier financial statements.

b. Additional information that OPM may request from the Carriers, including but not limited to:

i. All minutes of the meetings of directors and committees of directors or similar bodies of those charged with governance, or summaries of actions of recent meetings for which minutes have not yet been prepared. All significant actions of the directors and committees of directors or similar bodies of those charged with governance are included in the summaries.

ii. Any communications from regulatory agencies or others concerning noncompliance with, or deficiencies in, financial reporting practices;

c. Unrestricted access and the full cooperation of personnel within the Carrier from whom OPM determines it is necessary to obtain evidence.

4. Carriers must represent that there have been no:

a. Circumstances that have resulted in communications from the Carrier legal counsel reporting evidence of a material violation of law or breach of fiduciary duty, misappropriation of economic benefits that should have been used to offset claims made to the United States, or similar violations by the Carrier or any agent thereof.

b. Communications from any regulatory or government agency, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws or regulations, deficiencies in financial reporting practices, or other matters that could have a material adverse effect on the Carrier's financial statements.

5. The Carrier has identified and disclosed to you all provisions of laws, regulations, and contracts, applicable to the Carrier, noncompliance with which could have a material effect on the Carrier's financial information.

6. There are no known instances of non-compliance or suspected non-compliance with laws, regulations, contracts and grant agreements, whose effects should be considered when preparing the financial statements.

7. All material transactions have been recorded in the accounting records and are reflected in the financial statements.

8. The Carrier has satisfactory title to all owned assets. There are no liens or encumbrances on these assets and no assets have been pledged.

9. The Carrier has no plans or intentions that may materially affect the recognition, measurement, presentation, disclosure, or classification of assets and liabilities.

10. There are no guarantees under which the Carrier is contingently liable that require reporting in the financial statements.

11. No events have occurred subsequent to the date of the financial statements through the date of this letter that would require adjustment to the financial statements.

12. There are no known actual or possible litigation, claims, and assessments, whose effects s3ould be considered when preparing the financial statements.

13. Carriers acknowledge responsibility for the design, implementation, and maintenance of programs and controls to prevent, deter, and detect fraud; for adopting sound accounting policies; and for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of the financial statements, and to provide reasonable assurance against the possibility of misstatements that are material to the financial statements whether due to error or fraud. We understand that the term 'fraud' is defined as an intentional act by one or more individuals among management, those charged with governance, employees, or third parties, involving the use of deception that results in a misstatement in financial statements that are the subject of an audit.

14. Carrier has disclosed all deficiencies in the design or operation of internal control over financial reporting of which we are aware, which could adversely affect the Carrier's ability to initiate, authorize, record, process, or report financial data. Carrier has separately disclosed to OPM all such deficiencies that we believe to be significant deficiencies or material weaknesses in internal control over financial reporting. There are no deficiencies, significant deficiencies, or material weaknesses in the design or operation of internal control over financial reporting of which we are aware, which could adversely affect the Carrier's ability to initiate, authorize, record, process, or report financial data.

15. There have been no changes to internal control over financial reporting subsequent to September 30, 2025, or other conditions that might significantly affect internal control over financial reporting.

16. Carrier has disclosed to OPM the results of our assessment of the risk that the financial statements may be materially misstated as a result of fraud.

17. Carrier has no knowledge of any fraud or suspected fraud affecting the Carrier involving:

a. Drug rebates, volume discounts or any other economic benefit that is in any way related to healthcare costs incurred,

b. Management, Executives, or employees of the Carrier.

c. Others where fraud could have a material effect on the financial statements.

18. Carrier has no knowledge of any fraud or suspected fraud that resulted in a material misstatement to the Carrier's financial statements.

19. Carrier has no knowledge of any allegations of fraud, or suspected fraud, affecting the financial statements communicated by employees, former employees, regulators, or others.

20. Carrier has disclosed to OPM the identity of all of its related parties and all related party relationships and transactions of which it knows. Related party relationships and transactions and related amounts receivable from or payable to related parties (including sales, purchases, loans, transfers, leasing arrangements, and guarantees) have been properly accounted for in the financial statements in accordance with the 2026 FEHB and PSHB Programs Financial Reporting and Audit Guide.

21. Notwithstanding anything in this 2026 FEHB and PSHB Programs Financial Reporting and Audit Guide, OPM reserves the right to adjust, reset, or change any audit or testing standard it deems necessary to manage the program integrity of the FEHB/PSHB Plans.

Appendix C. OPM Contacts

Management Internal Control Letter should be sent to the following email addresses:

- FEHBIP@opm.gov (FEHB and PSHB), with a copy to their OPM Contracting Officer
- Ins-Carriers@opm.gov (FEHB)
- OCFO-PSHB@opm.gov (PSHB)

Please use the email subject line, "Management Internal Control Letter – (Plan Name) and (Contract Number)"

Technical questions regarding financial reporting and suggestions for improving financial reporting should be sent to the same email addresses.

Appendix D. Improper Payments Reporting Agreed-Upon Procedures

Introduction

The Payment Integrity Information Act of 2019 (PIIA) requires Federal agencies to improve efforts to identify and reduce government-wide improper payments, or IPs, and increase payment integrity across Federal programs. The Office of Management and Budget (OMB) published OMB Memorandum M-21-19, Appendix C to OMB Circular A-123, Requirements for Payment Integrity Improvement (Appendix C), on March 5, 2021. Under Appendix C, agencies are required to assess all programs and activities with annual outlays greater than $10M and identify those that are susceptible to significant improper payments, defined as "a payment that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements." Agencies are also required to report improper payments estimates on those programs and activities using a statistically valid sampling and estimation methodology plan (S&EMP). An S&EMP is considered statistically valid if it produces point estimates and confidence intervals around those estimates.

The term payment, under PIIA guidance, is defined as any disbursement or transfer of Federal funds to any non-Federal person, non-Federal entity, or Federal employee that is made by a Federal agency, a Federal contractor, a Federal grantee, or a governmental or other organization administering a Federal program or activity. All program outlays will fall into one of the following possible payment type categories: proper payment, improper payment, or unknown payment. The improper payments are further defined as overpayments, underpayments, and technically improper payments. The terms are defined as follows:

Proper Payment: A payment made to the right recipient for the right amount that has met all program-specific legally applicable requirements for the payment.

Improper Payment: A payment that was made in an incorrect amount under statutory, contractual, administrative, or other legally applicable requirements. There are 3 types of improper payments:

- *Overpayment*: A payment in excess of what is due. When an overpayment occurs, the improper payment amount is the difference between the amount due and the amount of which was actually paid. Overpayments are monetary loss type IPs.
- *Underpayment*: A payment that is less than what is due. When an underpayment occurs, the improper amount is the difference between the amount due and the amount which was paid. An underpayment is a non-monetary loss type IP.

- *Technically Improper Payment*: A payment made to an otherwise qualified recipient for the correct amount, but the payment failed to meet all applicable regulatory and/or statutory requirements. A technically improper payment is a non-monetary loss type of improper payment.

Unknown Payment: Payment that could be either proper or improper, but the agency is unable to discern whether the payment was proper or improper as a result of insufficient or lack of documentation.

Root causes are activities that lead to improper payments, that if corrected, would prevent the improper payment from occurring. Identifying root causes of improper payments is critical to formulating effective corrective actions. The root causes of improper payments must be identified, and corrective actions developed and monitored periodically to ensure future improper payments will be reduced and eliminated. OMB guidance provides root cause categories for identifying reasons improper payments occurred. The categorization is summarized in the table below:

Improper Payment Type	Root Cause Category Abbreviation	Description
Overpayments Underpayments	**Failure to Access Data/Information** **FA**	IPs are attributed to human errors to access the appropriate data/information to determine whether or not a beneficiary or recipient should be receiving a payment, even though such data/information exists and is accessible to the agency or entity making the payment.
Overpayments Underpayments	**Data/Information Needed Does Not Exist** **DI**	A situation in which there is no known database, dataset or location currently in existence that contains the data/information needed to validate the payment accuracy prior to making the payment.

Improper Payment Type	Root Cause Category Abbreviation	Description
Overpayments Underpayments	**Inability to Access Data/Information** **IA**	A situation in which the data or information needed to validate payment accuracy exists but the agency or entity making the payment does not have access to it.
Technically Improper Payments	**Statutory Requirements of Program Were Not Met** **SR**	A payment made to an otherwise qualified recipient for the correct amount but the payment process failed to meet all regulatory and/or statutory requirements. **All Technically IPs will fall into this cause category**.
Unknown Payments	**Unable to Determine Whether Proper or Improper** **UD**	A payment that could be either proper or improper but the agency is unable to determine whether the payment was proper or improper as a result of insufficient or lack of documentation. **All Unknown Payments will fall into this cause category**.

As part of the financial reporting requirements, all Experience-Rated Carriers are required to provide their Independent Public Accountant's (IPA's) documentation of the application of these improper payments reporting AUPs. This must include a statistically valid estimate of the annual amount of improper payments made by the Carrier. OPM will roll-up these estimates from all Experience-Rated Carriers who serve OPM to provide a nationwide estimate of the Federal Employees Health Benefits (FEHB) and Postal Service Health Benefits (PSHB) Experience-Rated Carriers Improper Payments and Unknown Payments.

In order to maintain standard reporting, OPM requires that all Experience-Rated Carriers must perform the Improper Payment Reporting Agreed Upon Procedures presented in this Appendix. OPM will not consider alternate procedures designed to produce similar results. The standardized reporting results are to be reported in the OPM AUP Reports spreadsheet.

This standardized data is needed for OPM to calculate the improper payment and unknown payment rate estimate for the Experience-Rated Carriers in the FEHB and PSHB Programs.

The Improper Payments Reporting Agreed-Upon Procedures must cover a 12-month timeframe that aligns with the financial reporting option the Carrier selected in the 2025 FEHB and PSHB Financial Reporting and Audit Guide. For Calendar Year AUP Reporters the 12-month timeframe is from January 1 through December 31. For Fiscal Year AUP Reporters the 12-month timeframe is from October 1 through September 30.

These AUPs provide instructions to IPAs as to how the statistical samples should be drawn and values that need to be included in reports to OPM. OPM requires that Carriers require their IPAs to perform the procedures presented in this Appendix.

AUP Process Structure

The AUP process starts with identifying the population universe, then selecting systematic random samples from that population. This process essentially creates the Sampling Plan the IPAs will be using. The next step is to Test the Sampling Plan. The records selected from the sample are then tested against the defined evaluation criteria, to identify all types of improper payments and determine their root causes. Once testing has been completed, the data from the sampling plan (i.e. population size, $ value of population, sample size, $ value of the sample size) and the results of the testing (i.e. $ value of sample tested, type of improper payment, $ value of improper payment, root cause of improper payment) are entered into the OPM AUP Reports spreadsheet. The IPAs are not required to perform any statistical calculations. The statistically valid improper payment estimate is automatically calculated by the spreadsheet based on the data entered. The final step of this process is to submit the completed OPM AUP Reports spreadsheet to OPM (see Section 8 – AUP Reporting – Instructions and Report Forms) along with the IPAs attestation and Corrective Action Plan.

Create the Sampling Plan (Population Universe and Sample Selection)

Creating the Population Universes

- Claims, transactions, line items should cover a 12-month timeframe.
- The universe must only capture the funds that were transferred/paid out for all strata (i.e. any payment over $0) during that 12-month timeframe.
- If there was no transfer of funds, then that transaction cannot be included in the population universe.
- Transactions involving negative values should not be included in the population universe.

Selecting Systematic Random Sample

IPAs may use any sampling technology to select the systematic random samples. Do not select a judgmental sample as this will take away the statistical validity of the data.

For IPAs not using such sampling software, below are the instructions for selecting systematic random samples. OPM is using Health Benefits Claims paid in this example, but this process must be applied to all sections of Appendix D.

For each subgroup of the Health Benefits Claims Paid universe, use the following steps to select a systematic random sample:

1. Compute a "Take Every" value, equal to the number of payees divided by 60.

   $$\text{Take Every} = \frac{\text{Number of Payee Claims in Group}}{60}$$

2. If "Take Every" is less than or equal to 1.0, take all the claims (there are fewer than 60).
3. For "Take Every" larger than 1.0, Pick a "Start With," a random integer between 1 and the Take Every.

   Start With = {1, 2, 3, …, Take Every}

4. Order the payee claim records by size of payment – this guarantees representation of large, medium, and small claims.
5. Calculate a table in Excel or some other spreadsheet that contains 60 rows – the 60 values you will sample:
   a. Column 1 – enter values 1 through 60 in the first 60 rows
   b. Column 2 – first row equals Start With
   c. Column 2 – second row equals value in row 1 plus Take Every – **Do Not Round**
   d. Column 2 – third row equals value in row 2 plus Take Every – **Do Not Round**
   e. Column 2 – continue to row 60, where the entry for each row equals the value of the row above plus the Take Every
   f. Column 3 – take the integer part of the value in column 1

6. The values in column 2 are the 60 records you will sample out of all the payee records ordered by size of claim.

   Example:

   For Group X:

Number of Claims =	440
Sample Size =	60
Take Every =	7.333333333

Start With = 5

Column 1	Column 2	Calculation	Column 3
Sample Record Number	Running Total	=Start with	Record to Test
1	5	=5	5
2	12.33333333	=5 + 7.333	12
3	19.66666667	=12.333 + 7.333	19
…	…	…	…
58	423	=415.667 + 7.333	423
59	430.333333	=423 + 7.333	430
60	437.6666667	=430.333 + 7.333	437

Use this same sampling methodology in selecting samples in sections 1 – 6 (Health Benefits Charges, LOCA, Cash & Equivalents, Admin Expenses, Refunds, Provider Charges) of this Appendix D.

Using Twice Sampling

- This will require the submission of two separate sets of OPM AUP Reports spreadsheets corresponding to the sample size for each occasion of sampling that covers the 12-month period. (Please note – the entire claims population is subject to sampling. All non-Hospital Part B services, other than Pharmacy/Prescriptions, should be part of Physicians category.)
- Carriers are required to use proportionate sampling sizes to avoid skewing the results. The IP estimate is statistically projected out to the population from which the sample was taken. Please note – the entire claims population, covering the 12-month period, is subject to sampling. Disproportionate sample sizes will prevent OPM from achieving an acceptable level of precision from the samples.
    - For example, if the sample size for a stratum is 60, the following proportions are acceptable for sampling twice per year:

Sample Size	1st Sample – Records Tested	# of months tested for 1st sample	2nd Sample – Records Tested	# of months tested for 2nd sample
60	30	6	30	6
60	35	7	25	5

Sample Size	1st Sample – Records Tested	# of months tested for 1st sample	2nd Sample – Records Tested	# of months tested for 2nd sample
60	40	8	20	4

- Suggested Cutoff Dates for Calendar Year AUP Reporters

Sample Size	1st Sample – Records Tested	Months tested for 1st sample	2nd Sample – Records Tested	Months tested for 2nd sample
60	30	Jan – Jun	30	Jul – Dec
60	35	Jan – Jul	25	Aug – Dec
60	40	Jan – Aug	20	Sep – Dec

- Suggested Cutoff Dates for Fiscal Year AUP Reporters

Sample Size	1st Sample – Records Tested	Months tested for 1st sample	2nd Sample – Records Tested	Months tested for 2nd sample
60	30	Oct – Mar	30	Apr – Sep
60	35	Oct – Apr	25	May – Sep
60	40	Oct – May	20	Jun – Sep

- The cutoff dates for the samples for each of the Financial Reporting Options is spelled out above.
- The samples for the two selections must sum to the required sample size for the year.

Test the Sampling Plan

The following Sections 1-6 identify and define what needs to be sampled and tested. Sections 1 and 4 are further divided into subgroups. After defining the section, instructions for testing that section are provided as well as instructions for reporting the results of the testing.

1. Health Benefits Claims Paid

Health Benefits Claims Paid means "all claims processed in the reporting period (Calendar year or Fiscal Year) which resulted in a transfer of funds to a provider for provision of health benefits." Health Benefits Claims Paid does not include adjustments resulting in return of funds from a provider (claims processed with a negative value), nor does it include denials or adjustments which result in no transfer of funds to or from a provider (claims processed with a $0 value).

Procedure to Sample Health Benefits and Pharmacy Claims Paid

Stratify the claims-paid universe into six payee subgroups (every claim needs to be in one and only one of the following subgroups/strata):

Strata for Sampling of Payees

Payment to:	Age of Covered Individual	
	Under age 65	65 and Over
Physician	**1**	**4**
Hospital	**2**	**5**
Pharmacy/Prescriptions	**3**	**6**

- From each subgroup, select a sample of 60 claims paid for a total of 360 claims paid to examine the accuracy and timeliness of claim payments.
- For this and other agreed-upon procedures, the sample size and level of examination are driven by OPM's obligation to provide a program-wide assessment of improper payments.
- Carriers are required to report Pharmacy/Prescriptions claims even if the payments are adjudicated by a contracted third party.
- The sample is to be drawn using a systematic random sample with a random start. **Do Not Select a Judgmental Sample**.
- This sample will be more than adequate to make usable determinations for the Carrier by the category of recipient (e.g. physician) or by age of covered individual.

Carriers will be allowed to sample twice per year in order to distribute their IPA's (auditor's) work.

Procedure to Test Health Benefits and Pharmacy Claims Paid Sample

For each claim selected (up to 360 total) from the Health Benefits Claims Paid sample universe, check for the Accuracy of Claim Payments and Timeliness of Claim Payments.

Carriers may contract with Pharmacy Benefits Managers (PBMs) to provide pharmacy benefits and services to members. The PBM is primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. Section 1.26 of the FEHB and PSHB Standard Fee for Service (FFS) Contract and Section 1.28 of the FEHB and PSHB Standard Experience-Rated HMO Contract outline transparency standards that require the PBM to provide pass-through transparent pricing. The IPA must review the performance of the PBM and the Carrier to ensure that costs charged to the FEHB and PSHB Programs, and services provided to their

members, are in accordance with the FEHB and PSHB Programs Standard Contracts, the PBM and pharmacy agreements, and federal regulations.

IPAs are required to perform the procedures presented in this Appendix and report the results in the OPM AUP Reports spreadsheet. The PBM's IPAs may perform these procedures for testing the Pharmacy claims. If the PBM's IPA performs these AUPs, the PBM's IPA must provide the Carrier information for all claims tested. The Carrier must include all results of testing in the OPM AUP Reports spreadsheet.

Perform the following for each claim selected from the Health Benefits Claims Paid sample universe, which includes the Pharmacy strata:

Accuracy of Claim Payments:

- Determine Eligibility
    - Compare the claimant's name and other identifying information to the Carrier's eligibility files and determine eligibility.
- Accuracy of Claim Amount
    - Inspect documentation evidencing accuracy of claim amount.
- Allowability of Claim
    - Inspect documentation evidencing allowability of claim and compare with the terms of the contract.
- Compare Claim Amount to General Ledger
    - Compare evidence of claim amount with claim amount recorded in the general ledger.
- Application of Member Cost Share
    - Inspect documentation supporting proper application of member cost share.
- Application of Coordination of Benefits (COB)
    - Inspect documentation supporting proper application of coordination of benefits (COB).
- Compliance with Provider Agreements (claim population of Physician and Hospital)
    - Obtain agreements detailing arrangements the Carrier has established with its providers for discounts and settlements.
    - Review the provider agreements for claims sampled and determine whether the claims paid are in compliance with provider agreements.
- Compliance with Pharmacy/Network Agreements (claims population of Pharmacy)

- Request full unredacted copies of the PBM's pharmacy/network agreements, along with retail pharmacy agreements needed to review the claims sample.
- Review the agreements for claims sample to determine if the Carrier and the PBM followed transparency standards as stated in the FEHB and PSHB standard contracts.

For claim populations of covered individuals age 65 and over, also perform the following:

- Obtain History File
  - Obtain the covered individual's history file (for up to 6 months) of subsequent information.
- Check for Other Insurance Coverages
  - Inspect documentation that identifies other insurance coverages (Medicare, etc.) impacting coordination of benefits (COB).
- Retroactive Application of Coverage
  - Recalculate COB amounts due OPM for retroactive application of coverage.
- Amount Charged to Program agrees with Remittance/Check
  - Determine whether the amount of the claim and the amount charged to the Program agree with the amount on the remittance advice to provider, or amount of the check.

Procedure to Report Findings for Health Benefits and Pharmacy Claims Paid

Evaluation of Accuracy of Claim Payment: Identify all payments with errors, including monetary amounts found, for each subgroup sample (stratum) and report the claim amounts and error as a finding. Discrepancies of less than $1 as a result of rounding, should not be reported as an improper payment. Report the findings in Appendix E – IPA Reports, Section 2 – Schedule of Findings and Questioned Amounts. Any adjustments made to correct improper payments identified in the sampling and testing should be reported in the Current & Prior Years' Findings tab discussed in more detail below.

Timeliness of Claim Payments. Using the sample derived above, calculate the average number of working days from the date a claim was received to the date it is adjudicated (paid, denied, or a request for further information is sent out), for the given time period.

Evaluation of Timeliness of Claim Payments: If the cumulative percentage of average days for all subgroups exceed the standards expressed in Section 1.9(f)(4) for fee-for service Carriers and Section 1.9(g)(2) for experienced-rated HMO Carriers, of the standard contract, report the results as a finding.

For each instance identified in the Accuracy of Claim Payments identify the type of improper payment (Overpayment, Underpayment, Technically Improper payment, or Unknown payment), as appropriate, and identify the amount of the improper payment.

For each type of improper payment identified, assign the appropriate root cause category. Please refer to the Root Cause Category Table in the Introduction section of this Appendix D.

Enter results of all records tested into the data file. Use the attached OPM AUP Reports spreadsheet, AUP Test Results Table tab. Please note that for each record tested, report only one type of improper payment. Detailed instructions for entering the data are in the AUP Reporting Requirements section of this document.

Carriers are required to report Pharmacy/Prescriptions claims even if the payments are adjudicated by a contracted third party. The PBM's IPAs may perform these AUPs for testing the Pharmacy claims, in accordance with attestation standards established by the American Institute of Certified Public Accountants. Their results must be reported to the Carrier using the OPM AUP Reports spreadsheet. The Carrier must incorporate these results into their OPM AUP Reports submission to OPM.

In addition, complete Table 6 –Average Number of Days to Pay Claims in the report form regarding time to adjudication. This table is in the AUP Reporting Requirements section of this document. Enter the data into the attached OPM AUP Reports spreadsheet, Table 6 – Avg Days to Pay Claims tab.

Carriers must report all findings in the OPM AUP Reports spreadsheet, Current & Prior Year's Findings tab. See instructions in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

2. Letter of Credit Authorizations

Please note: This section is not part of the sampling universe for calculating the improper payment estimate as there is a potential for double counting payments with Health Benefits Charges and Administrative Expenses. The dollar amount of the letter of credit account (LOCA) drawdown for the 12-month timeframe represents the Carrier's total disbursements. However, the following procedures still need to be performed and reported in Table 7 - LOCA.

Also, please note: This section applies to Carriers that may have received waivers from the LOC accounting. Any such waiver is void and permits OPM to audit any financial transaction.

Procedure to Sample LOCA Records

Select a systematic random sample of 60 withdrawals from the Carrier's LOCA. All the Carrier's LOCA accounts must be subject to having a sample drawn from them. If there are less than 60 LOCA transactions during the period, a 100% sample will be taken. Follow the instructions given above in Selecting a Systematic Random Sample section.

Procedures to Test Sample LOCA Records

- **Examine Withdrawals:** Examine the withdrawals and confirm that the amounts withdrawn are supported by claims invoices, administrative expense vouchers or other documentation, and compare the total dollar value of the supporting documentation with the amounts withdrawn.

- **Inspect Withdrawals:** Compare the date the checks issued for Program disbursements were presented to the Carrier's bank with the date of the withdrawals.

Procedure to Report Findings for LOCA Records

Evaluation of LOCA Withdrawals: Compile the number of times that the dollar value of the LOCA withdrawal exceeds the dollar value of the supporting documentation. In each case identified, report the amount of the excess. In addition, compile the number of times that LOCA withdrawals occur before checks issued for Program disbursements are presented to the Carrier's bank. Complete Table 7 report form, located in the OPM AUP Reports spreadsheet.

Report all findings in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

3. Cash and Equivalents

Procedures to Sample Uncashed Checks

- Inspect a random sample of 60 uncashed checks. Follow the instructions given in Selecting a Systematic Random Sample section.

- The sampling technique to be used is a systematic random sample with random start.

- If there are less than 60 uncashed checks during the period, a 100% sample will be taken.

- Identify and tally all checks from the sample group outstanding for two years or more.

- This will be a systematic random sample with a random start.
- Compare the amounts represented by these checks with the corresponding amounts credited to the Program, and
- Identify those checks that were credited later than the 25th month after issuance or not credited at all.

Procedures to Test Uncashed Checks Sample

Evaluation of Uncashed Checks: Compile the number of instances that checks issued for the Program and outstanding for two years have been credited to the Program later than the 25th month after issuance or not credited to the Program and report the results as a finding.

Procedures to Report Findings for Uncashed Checks

For each instance identified, report the error amount and identify the type of improper payment (Overpayment, Underpayment, Technically Improper payment, or Unknown payment), as appropriate.

For each type of improper payment identified, assign the appropriate root cause category. Please refer to the Root Cause Category Table in the AUP Reporting Requirements section of this document.

Enter results of all records tested into the data file. Use the attached OPM AUP Reports spreadsheet, AUP Test Results Table tab. Please note that for each record tested, report only one type of improper payment. Detailed instructions for entering the data are in the AUP Reporting Requirements section of this document.

Report all findings in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

4. Administrative Expenses

A sample of administrative expenses may be selected twice during the year, (as with the claims paid) to distribute the auditor's work. Carriers are required to use proportionate sampling sizes to avoid skewing the results. The IP estimate is statistically projected out to the population from which the sample was taken. Please note – the entire administrative expenses population, covering the 12-month period, is subject to sampling. Disproportionate sample sizes will prevent OPM from achieving an acceptable level of

precision from the samples. The samples for the two selections must sum to the required sample size for the year.

Carriers must submit two separate OPM AUP Reports spreadsheets for each occasion of sampling.

Procedures to Sample Administrative Expenses

Stratify the administrative expenses into four subgroups and select a systematic random sample with random start of each expense population:

(1)	salaries and fringe benefits,	compliance test sample size = 120
(2)	pension costs,	compliance test sample size = 60
(3)	Post-Retirement benefits,	compliance test sample size = 60
(4)	all other	compliance test sample size = 60

If there are less than the required sample size of transactions, a 100% sample will be taken.

Salaries and fringe benefits will both be tested in each of the 120 samples. Pension cost allocations from a parent organization must be validated. Such a procedure will likely vary from Carrier to Carrier.

The sample unit is general ledger transactions for each subgroup. Follow the instructions given in the Selecting a Systematic Random Sample section for sample selection. Each subgroup is defined as follows:

1. Salaries and fringe benefits
    - Obtain the general ledger detail of salary expense for the period.
2. Pension costs
    - Obtain the general ledger detail of pension costs for the period.
3. Post-retirement benefits
    - Obtain the general ledger detail of post-retirement benefits for the period.
4. All Other Expenses
    - Obtain the general ledger detail by journal entry line for all other expenses (e.g., admin fees, non-recurring items, rental charges, printing and supplies, postage, travel, etc.) for the period.

Procedures to Test Administrative Expenses Sample

For each of the 300 sample items, check for Allowable Charges and Manual Adjustments.

Allowable Charges. For each sample item:

- **Verify Transactions with Invoices**
  - Inspect documentation evidencing that each transaction was supported by invoices or other documentation.
- **Determine Allowability**
  - Compare charges to the criteria prescribed for allowability of charges as defined in the contract cost principles procedures found in 48 Code of Federal Regulations (CFR), part 31 and 1631.
- **Determine Allocability**
  - Inspect documentation evidencing the charges were allocable to the contract, as defined in 48 CFR 31.201-4.
- **Determine Reasonableness**
  - Compare charges to definition of reasonable charges as described in 48 CFR 31.201-3.

Evaluation of Allowable Charges: Report as a finding all instances where administrative charges made to the Program were not in accordance with the contractual terms (allowable, allocable, reasonable) or the charges were not supported by appropriate documentation. Discrepancies of less than $1 as a result of rounding, should not be reported as an improper payment. Report all findings in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

Manual Adjustments. For each sample item, determine if it was a manual adjustment. If so, perform the following:

- **Confirm Supporting Documentation Matches Manual Adjustments**
  Inspect all manual adjustments to administrative expenses made after period-end closing and compare the adjustments with the corresponding supporting documentation.

  Evaluation of Manual Adjustments – Supporting Documentation: Report as a finding all instances where supporting documentation did not exist for manual adjustments under the terms 48 CFR, part 31 and 1631 (Contract Cost Principles and Procedures).

- **Confirm Manual Adjustments are Allowable**
  Inspect all manual adjustments to administrative expenses made after period-end closing and compare the adjusted administrative costs with the charges allowable by 48 CFR, part 31 and 1631(Contract Cost Principles and Procedures).

Evaluation of Manual Adjustments - Allowable: Report as a finding all instances where adjusted administrative costs were not allowable charges under the terms 48 CFR, part 31 and 1631.

If the Administrative Expenses – Other category/stratum contains nonrecurring items and rental charges, then also perform the following:

Nonrecurring Items. Review any nonrecurring items such as gain or loss on sale of assets to ensure that the Program was administered according to 48 CFR 31.205-16.

Evaluation of Nonrecurring Items: Report as a finding all instances where the Program was not in accordance with 48 CFR 31.205-16.

Rental Charges. Review samples of rental charges transactions (involving different properties) according to 48 CFR 31.205-36 (rental costs).

Note any items with rental costs; treatment under a sale and leaseback agreement; and charges for rent between any divisions, subsidiaries, or organizations under common control.

Evaluation of Rental Charges: Report as a finding all instances where amount charged exceeds allowable amounts according to 48 CFR 31.205-36 (rental costs).

Procedures to Report Findings for Administrative Expenses

For each instance identified in Allowable Charges, Manual Adjustments, Nonrecurring Items, and Rental Charges, report the error amount and identify the type of improper payment (Overpayment, Underpayment, Technically Improper payment, or Unknown payment), as appropriate.

For each type of improper payment identified, assign the appropriate root cause category. Please refer to the Root Cause Category Table in the AUP Reporting Requirements section of this document.

Enter results of all records tested into the data file. Use the attached OPM AUP Reports spreadsheet, AUP Test Results Table tab. Please note that for each record tested, report only one type of improper payment. Detailed instructions for entering the data are in the AUP Reporting Requirements section of this Appendix D.

Report all findings in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

5. Refunds

Accounting Policies and Procedures. Inspect the Carrier's accounting policies and procedures used to account for solicited and unsolicited claims refunds and determine whether the policies and procedures are in accordance with the contract.

Evaluation of Accounting Policies and Procedures: Report as a finding all instances where the Carrier lacks policies and procedures to account for claims refunds or where policies and procedures do not agree with the contract.

The findings of this evaluation should be reported in the OPM AUP Reports spreadsheet, Current & Prior Year's Findings tab. See the instructions in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

Procedure to Sample Refunds

Refund Transactions. Select a systematic random sample with a random start of 60 claims refund transactions (resulting from direct and indirect charges). If there are less than 60 transactions, a 100% sample must be taken. Follow the instructions given in Selecting a Systematic Random Sample section for sample selection.

Procedures to Test Refunds Sample

For each sample item, perform the following:

- Compare refunds allocable to the Program in accordance with the requirements in the FEHB contract, Section 2.3.
- For refunds that were indirectly charged to the Program, but where the proportionate share of the charge or associated refund cannot be identified, compare the Program refund with an amount derived from the application of a percentage (Program's share of the Carrier's business proportionate to the Carrier's total business) to the total refund amount.
- Coordination of Benefits (COB) Refunds Properly Applied to Contract
    - Select COB refunds and determine that they were properly applied to the contract.

Evaluation of Refund Transactions: Report as a finding all instances where refunds (directly or indirectly) associated with the Program are not credited to the Program in accordance with the requirements in the FEHB contract, Section 2.3.

Outstanding Refunds. Compare the outstanding refunds report to the total refunds reported in the general ledger.

Evaluation of Outstanding Refunds: Report as a finding all instances where the outstanding refunds report does not agree with the general ledger.

Discounts/Settlements Returned to the Program.
Tally the number of transactions where amounts resulting from provider discounts/settlements were returned to the Program in accordance with FEHB Contract Section 2.3.

Evaluation of Discounts/Settlements Returned: Report as a finding the number of instances where the Carrier does not credit the Program in accordance with the terms of the agreements and does not return funds benefited from the discounts/settlement arrangements in accordance with FEHB Contract Section 2.3.

Procedures to Report Findings for Refunds

For each instance identified in Refund Transactions, Outstanding Refunds, and Discounts/Settlements Returned, report the error amount and identify the type of improper payment (Overpayment, Underpayment, Technically Improper payment, or Unknown payment), as appropriate.

For each type of improper payment identified, assign the appropriate root cause category. Please refer to the Root Cause Category Table in the AUP Reporting Requirements section of this Appendix D.

Enter results of all records tested into the data file. Use the attached OPM AUP Reports spreadsheet, AUP Test Results Table tab. Please note that for each record tested, report only one type of improper payment. Detailed instructions for entering the data are in the AUP Reporting Requirements section of this document.

Carriers must report all findings in the OPM AUP Reports spreadsheet, Current & Prior Year's Findings Tab. See instructions in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

6. Provider Charges

Procedures to Sample Provider Charges

Compliance with Provider Agreements.
Inspect a sample of 30 Carrier settlements and document and determine whether they comply with provider agreements. If there are less than 30 settlements, a 100% sample must be taken. Follow the instructions given in Selecting a Systematic Random Sample section for sample selection.

Procedures to Test Sample Provider Charges

Compare the settlement received by the Program with the terms of the agreements.

> **Evaluation of Compliance with Provider Agreements:** Report as a finding the number of instances where the Carrier settlements do not comply with provider agreements.

Retroactive Settlements. Inspect payment/pricing methodology and determine if the methodology allows for retroactive settlements to occur.

> **Evaluation of Retroactive Settlements:** Report as a finding the number of instances where the Carrier cannot identify discounts and settlements.

Procedures to Report Findings for Provider Charges

For each instance identified, report the error amount and identify the type of improper payment (Overpayment, Underpayment, Technically Improper payment, or Unknown payment), as appropriate.

For each type of improper payment identified, assign the appropriate root cause category. Please refer to the Root Cause Category Table in the AUP Reporting Requirements section of this Appendix D.

Carriers must report all findings of this evaluation in the OPM AUP Reports spreadsheet, Current & Prior Year's Findings tab. See instructions in Appendix E – Sample IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts.

7. Status of Prior Year Findings

If the Carrier was subject to the Guide in the prior year, update the status of prior year findings. Obtain the Carrier's corrective action plan from the prior year. Obtain an update on the status of each finding from the prior year. Verify that the actions indicated were completed by the Carrier by viewing evidence from the plan. Carriers must report all prior year findings in the OPM AUP Reports spreadsheet, Current & Prior Year's Findings tab. Also, see Appendix E – Sample IPA Reports, Section 3 – Illustrative Comments on Resolution of Prior Year's Examination Findings and Section 4 – Illustrative Corrective Action Plan for Material Weaknesses or Findings.

AUP Reporting Requirements – Instructions and Report Forms

Carriers are required to conduct one AUP per contract that covers the plan codes for that contract.

For the AUP reporting process, Carriers will be required to submit the 2026 OPM AUP Reports spreadsheet. The spreadsheet includes 6 tabs:

1. IPs Defined by Activity (data entry required)
2. AUP Test Results Table (data entry required)
3. Statistical Tables (automatic calculations – no data entry required)
4. Table 6 –Avg Days to pay Claims
5. Table 7 - LOCA Table; external report (outside of sample universe; data entry required)
6. Current and Prior Years Findings (data entry required)

The narrative below provides instructions on completing the IP reporting spreadsheet and Tables.

For Carriers that will be sampling twice per year, they are required to use proportionate sampling sizes to avoid skewing the results. The IP estimate is statistically projected out to the population from which the sample was taken. Please note – the entire claims population, covering the 12-month period, is subject to sampling. Disproportionate sample sizes will prevent OPM from achieving an acceptable level of precision from the samples. The samples for the two selections must sum to the required sample size for the year. Please see the Using Twice Sampling section in this Appendix D.

OPM AUP Reports Spreadsheet – Data Entry (Excel Spreadsheet)

The 2026 OPM AUP Reports spreadsheet is organized into six tabs; IPs defined by Activity, AUP Test Results Table, Statistical Tables, Table 6 – Avg Days to Pay Claims, Table 7 – LOCA, and Current and Prior Year's Findings.

The **IPs Defined by Activity tab** requires data entry of summary information on the total number of claims and the dollar value paid. It also requires data entry of the information for the number of sampled claims and its corresponding dollar value. This is visually presented in Table 1 below, IPs Defined by Activity.

The **AUP Test Results Table tab** requires data entry of the results from testing each of the samples. This includes the type of improper payment identified, the dollar amount of the improper payment, and the root cause category for that improper payment.

Statistical Tables tab -- The data entered into the first two tabs, will automatically populate and produce Statistical Tables 2-5; the statistical calculation tables needed to

project the IP estimate from the sample to the entire Carrier population. The tables are defined as:

- Table 2 – Results of IP Testing
- Table 3 – Monetary vs. Non-monetary IP Findings
- Table 4 – Known vs. Unknown Types of IP
- Table 5 – Amount of IP by Root Cause Category

The data from these tables will be aggregated across all Experience-Rated Carriers to produce the improper payment estimate for the FEHB Program - Experience-Rated Activity.

The **Table 6 – Avg Days to Pay Claims tab** requires the data entry of the total number of days (cumulative across the sample) required to pay the sampled claims. This is the table referenced in section 1. Health Benefits Charges of this Appendix D.

The **Table 7 - LOCA tab** requires the data entry of the results of the evaluation of Letter of Credit Authorizations. This is the table referenced in section 2. Letter of Credit Authorizations of this Appendix D.

The **Current & Prior Year Findings tab** requires the data entry of the schedule of findings and questioned costs for the current year and comments on resolution of prior year's examination findings. See instructions in Appendix E – IPA Reports, Section 2 – Illustrative Schedule of Findings and Questioned Amounts and Section 3 – Illustrative Comments on Resolution of Prior Year's Examination Findings.

Note: The data in Table 6 and Table 7 is not factored into the calculation of the IP estimate. However, the test results are captured and analyzed separately.

Instructions for Completing the IPs defined by Activity Tab

Start by entering the Plan Name in cell A2 and Contract Number in Cell B2.

Next, enter the Reference Period Start and End Date (i.e. the 12-month timeframe that aligns with the dates for Calendar Year AUP Reporters or the dates for Fiscal Year AUP Reporters).

For Carriers sampling twice per year, enter the cutoff dates for the two samples (refer to the tables in the Using Twice Sampling section of this Appendix D).

Enter the number and dollar amounts in each of the 13 stratums for the Population universe and the Sample population. The 13 stratums are defined below in Table 1.

The table below is a **visual representation** of what data needs to be entered into the spreadsheet. This is for reference only. Actual data entry should be done in the spreadsheet. Note: For those Carriers sampling twice per year, the number sampled needs to be adjusted in each of the two separate spreadsheets submitted. The sum of the two samples should match the required sample size.

Table 1. IPs Defined by Activity (data to be entered in OPM AUP Reports spreadsheet)

Plan Name	Contract #
<enter plan name>	*<enter contract number>*

Reference Period Start Date (mm/dd/yyyy)	Reference Period End Date (mm/dd/yyyy)

Stratum #	AUP Section (Stratum)	Population - Number	Population - $ value	Sample - Number	Sample – $ value
	1. Health Benefits Claims Paid	0	$0	360	**$0**
1	1a. Physician <65			60	
2	1b. Hospital <65			60	
3	1c. Pharmacy <65			60	
4	1d. Physician >65			60	
5	1e. Hospital >65			60	
6	1f. Pharmacy >65			60	
7	3. Cash & Equivalent			60	
	4. Admin Expenses	0	$0	300	**$0**
8	4a. Salaries & fringe			120	
9	4b. Pension			60	
10	4c. Post-retirement			60	
11	4d. All Other (e.g. non-recurring items, rental charges, printing, admin fees, etc…)			60	
12	5. Refunds			60	
13	6. Provider Charges			30	
Totals		**0**	**$0**	**810**	**$0**

1. Enter the number and dollar amounts of the Population universe (N).
    a. For each stratum enter the number of records in the population and the dollar amount **(positive whole number rounded to the nearest dollar)** of the records in the population. Negative numbers are not permitted.
        1a. Health Benefit Charges – Physician <65
        1b. Health Benefit Charges - Hospital <65
        1c. Health Benefit Charges - Pharmacy <65
        1d. Health Benefit Charges - Physician >65
        1e. Health Benefit Charges - Hospital >65
        1f. Health Benefit Charges - Pharmacy >65
        3. Cash & Equivalents (uncashed checks)
        4a. Admin Expenses – Salaries & Fringe
        4b. Admin Expenses – Pension
        4c. Admin Expenses – Post-Retirement
        4d. Admin Expenses – All Other (e.g. non-recurring items, rental charges, printing, admin fees, etc…)
        5. Refunds
        6. Provider Charges
    b. **If there are no records in the population, enter zero for both the number and dollar amount. Also enter zeros for the sample size and sample dollar amount.**
    c. Note: The totals are automatically calculated

2. Enter the number and dollar amounts of the Sample population (n).
    a. For each stratum, enter the number of records sampled for testing and the dollar amount **(positive whole number rounded to the nearest dollar)** of those records in the sample. Negative numbers are not permitted.
    b. If there are less than required sample size of transactions, then 100% of sample needs to be reported.
    c. **If there are no records in the population, enter zero for both the number and dollar amount.**
    d. Note: The totals are automatically calculated.

Instructions for AUP Test Results Table Tab

Enter the results of testing the samples (type of improper payment, improper payment amount, root cause category) . Data is only to be entered in the cells in columns D through P

of the spreadsheet. Names of the columns are listed below. **Please Note: Each record can only have one type of improper or unknown payment.**

All other cells in this tab are locked from any data entry.

Column	Column Name
Column D	$ value of sample
Column E	Overpayment
Column F	$ Overpayment
Column G	Root Cause Over
Column H	Underpayment
Column I	$ Underpayment
Column J	Root Cause Under
Column K	Tech IP
Column L	$ Tech IP
Column M	Root Cause Tech
Column N	Unknown Payment
Column O	$ Unknown Payment
Column P	Root Cause Unknown

Identify and Quantify Appropriate Sample Record Tested per Each Stratum

a. Start with stratum 1 (HB Charges 1, DR<65), record 1 and enter the dollar ($) amount of the sample tested from the corresponding stratum **(positive whole number rounded to the nearest dollar)**. Negative numbers are not permitted.
b. Data entry for this field is a mandatory requirement. Even if there were no findings during the audit, we need to collect the dollar amount of the sample that was tested.
c. This field is auto formatted. No dollar sign needed.
d. Continue this process for each record tested in the stratum.
e. For those Carriers sampling twice per year, two spreadsheets will need to be submitted. Each spreadsheet should start from record 1 of their respective stratum.

Identify and Enter the Type of Improper Payment

a. If the testing result found an improper payment, then identify the type of improper payment and locate the appropriate column for that record:
    i. Overpayment (column E - Overpayment)
    ii. Underpayment (column H - Underpayment)
    iii. Technically Improper (column K - Tech IP)
    iv. Unknown Payment (column N - Unknown Payment)
b. Enter an "x" (**lowercase**) in the respective column for that record.

c. **Note: Each record can only have one type of improper or unknown payment. The improper or unknown payment cannot be split into any combination of overpayment, underpayment, technically improper, or unknown payment.**
d. If the testing result of the record found no improper payment, leave that record blank. No data entry required for proper payments.
e. If 100% of the sample is less than the required sample size, report 100% of those records. Leave the remaining rows for that stratum blank. The number of records tested in the sample and reported in this tab should match the sample size number for that stratum in the IPs defined by Activity tab.

Enter the Dollar Amount of the Improper Payment

f. Enter the dollar ($) amount of the improper payment as a **positive** whole number rounded up to the nearest dollar (negative numbers are not permitted), in the respective column:
    i. Overpayment dollars (column F - $Overpayment)
    ii. Underpayment dollars (column I - $Underpayment)
    iii. Technically Improper dollars (column L - $Tech IP)
    iv. Unknown payment dollars (column O - $Unknown Payment)
b. The dollar ($) amount fields are auto formatted. No dollar sign is needed.

Select the Root Cause Category for the Improper Payment

a. Choose the Root Cause category for each of the improper payments identified.
b. Select the appropriate root cause category for each improper payment in the respective column.
    i. Root Cause Overpayment (column G – Root Cause Over)
    ii. Root Cause Underpayment (column J – Root Cause Under)
    iii. Root Cause Technically Improper (column M – Root Cause Tech)
    iv. Root Cause Unknown payment (column P – Root Cause Tech)
c. For Overpayments and Underpayments there will be choice, via drop down menu, of 3 root cause categories:
    i. FA – Failure to Access

        IPs are attributed to human errors to access the appropriate data/information to determine whether or not a beneficiary or recipient should be receiving a payment, even though such data/information exists and is accessible to the agency or entity making the payment.
    ii. DI – Data/Information Does Not Exist

A situation in which there is no known database, dataset or location currently in existence that contains the data/information needed to validate the payment accuracy prior to making the payment.

iii. IA – Inability to Access

A situation in which the data or information needed to validate payment accuracy exists but the agency or entity making the payment does not have access to it.

d. For Technically Improper payments, the root cause is always SR – Statutory Regulations not followed. The spreadsheet will autofill this value.

A payment made to an otherwise qualified recipient for the right amount but the payment process failed to meet all regulatory and/or statutory requirements.

e. For Unknown Payments, the root cause category is always UD – Unable to Determine if proper or improper. The spreadsheet will autofill this value.

A payment that could be either proper or improper but the agency is unable to determine whether the payment was proper or improper as a result of insufficient documentation or lack of documentation.

The table below is a partial snapshot from the OPM AUP Reports spreadsheet, AUP Test Results Table tab. This is test data meant to show the data entry process.

AUP Section	Sample Number	Unique Sample ID	$ value of sample	Overpayment	$ Overpayment	Root Cause Over
HB Claims Paid 1	1	DR<65 – 1	$222			
HB Claims Paid 1	2	DR<65 – 2	$69			
HB Claims Paid 1	3	DR<65 – 3	$32	x	$10	FA
HB Claims Paid 1	4	DR<65 – 4	$76			
HB Claims Paid 1	5	DR<65 – 5	$13			
HB Claims Paid 1	6	DR<65 – 6	$223			
HB Claims Paid 1	7	DR<65 – 7	$119			
HB Claims Paid 1	8	DR<65 – 8	$226			
HB Claims Paid 1	9	DR<65 – 9	$162			
HB Claims Paid 1	10	DR<65 – 10	$229			

In this example above, record 3 from the HB Charges stratum/subgroup 1 (i.e. for payments made to Physicians from the Age Group of members less 65 years old), contained an improper payment.

- The $ value of the claim in the sample was $32. The value "32" was entered in the cell "$ value of sample".
- Improper payment was identified as an "Overpayment" and an "x" was entered in the Overpayment column under the corresponding cell.
- Amount of the improper payment was "$10". The value of "10" was entered in the $ Overpayment column under the corresponding cell.
- The root cause category of this overpayment identified was "Failure to Access Data". A drop-down menu was pulled down for that cell in the Root Cause Over column and FA was selected.
- The other nine records in this example did not have any improper payments. Therefore, no data was entered into the cells for the types of improper payments nor root cause categories. **Carriers are still required to enter the dollar value of the sample tested.**

Continue this data entry for each record in each of the 13 stratums. The total number of records tested should not exceed 810.

As the data is being entered for each record, the OPM AUP Reports spreadsheet automatically populates the cells in Tables 2, 3, 4, and 5. Each of those cells contain formulas that calculate all the necessary statistical information required.

The tables below provide a visual representation of the data being reported/populated. This is for reference only. Carriers are not required to perform any statistical calculations. The focus of the Carriers is on reporting the population data and the results of the testing of the samples.

Table 2. Results of IP Testing (table auto generated in OPM provided spreadsheet)

Program/Activity Disbursements:

Program/Activity Disbursements:	

Reference Period	**Date**
Beginning	
Ending	

Universe	***Total***
Number of Disbursements	

Universe	*Total*
Total Disbursements ($000)	

Sample	Total
Number of Disbursements	
Total Disbursements ($000)	
Coverage	

Un-weighted Errors (records with an IP or UP determination)	Total
Number	
Percentage of Number of Disbursements	
Total IP and UP Payments ($000)	
Percentage of Sample Disbursements	

Statistical Projections	Total
Total IP and UP Payments ($000)	
95% Margin of Error ($000)	
95% Lower Limit ($000)	
95% Upper Limit ($000)	

As a % of Universe	Total
Total IP and UP Payments	
95% Lower Limit	
95% Upper Limit	

Table 3 – Monetary vs. Non-Monetary IP Finding (table auto-generated in OPM provided spreadsheet)

Type of IP	$Dollars	Number of Samples	Percent IP
Monetary			
Non-Monetary			
Total	**$0**	**0**	

Table 4 – Known vs. Unknown Types of IP (table auto-generated in OPM provided spreadsheet)

Type of IP	$Dollars	Number of Samples	Percent IP
Known			
Unknown			
Total	**$0**	**0**	

Table 5 – Amount of IP by Root Cause Category (table auto-generated in OPM provided spreadsheet)

Improper and Unknown Payment	SR	UD	FA	DI	IA	Total IP + UP
Amount $(000) (IP + UP)						
Improper Payment (IP) Amount						
Overpayments (monetary)						
Underpayments (non-monetary)						
Technically Improper (non-monetary)						
Percent of Improper Payment						
Unknown Payment (UP) Amount						
Percent of IP + UP						

Cause Category	Description
SR	Statutory Requirements of Program Were Not Met
UD	Unable to Determine Whether Proper or Improper
FA	Failure to Access Data/Information
DI	Data/Information Needed Does Not Exist
IA	Inability to Access Data/Information

Carriers must complete Table 6 regarding Time to Adjudication and Table 7 regarding Letter of Credit Authorizations, using the table format below. Both of these tables are in the OPM AUP Reports spreadsheet. Carriers must enter the data in the spreadsheet.

Table 6 – Average Number of Days to Pay Claims by Age of Covered Individuals

Group	<65	>65
Physician		
Hospital		
Pharmacy/Scripts		

Group	<65	>65
Cumulative Percentage Processed within 30 days		

Table 7 – Letter of Credit Authorizations

LOCA	Number in Population	$ in Population	Number Sampled	$ of Sample	# of times $ are in Excess	$ in Excess	# of times early LOCA Withdraws
Letter of Credit Authorizations	0	$0	60	$0	0	$0	0

Saving the OPM AUP Reports Spreadsheet

Once data entry has been completed and reviewed, Carriers must use the following naming convention for saving the spreadsheet:

OPM AUP Reports Abbreviated Plan Name Contract Number.xlsx

The Abbreviated Plan Name should be limited to 6 characters maximum
Contract number cannot contain any dashes.

For PSHB Carriers, please add a "P" to the naming convention

This is an example of the naming convention.
The Carrier's abbreviated plan name is ABCDEF.
The Carrier's contract number is: 1234-5.

OPM AUP Reports ABCDEF 12345.xlsx

If this was a PSHB Carrier then the naming convention would be:

OPM AUP ReportsP ABCDEF 12345.xlsx

For Carriers sampling twice per year:

This will require the submission of two separate sets of OPM AUP Reports spreadsheets corresponding to the sample size for each occasion of sampling that covers the 12-month period. Carriers are required to use proportionate sampling sizes to avoid skewing the results.

Carriers who elect twice sampling for some strata but not all will submit two spreadsheets with their submission. The first spreadsheet would have only the first

sampling strata filled out with the results of the first sampling. The second spreadsheet would have all the sections filled out, including the second sampling.

Carriers must use this additional formatting (i.e. adding a 1 and 2 to differentiate the 2 spreadsheets):

OPM AUP Reports Abbreviated Plan Name Contract Number -1.xlsx

OPM AUP Reports Abbreviated Plan Name Contract Number -2.xlsx

For PSHB Carriers, please add a "P" to the naming convention.

OPM AUP ReportsP Abbreviated Plan Name Contract Number -1.xlsx

OPM AUP ReportsP Abbreviated Plan Name Contract Number -2.xlsx

This is an example of the naming convention.
The Carrier's abbreviated plan name is UVWXYZ.
The Carrier's contract number is: 6789-A.

the first sample would be saved as:
OPM AUP Reports UVWXYZ 6789A -1.xlsx

the second sample would be saved as:
OPM AUP Reports UVWXYZ 6789A -2.xlsx

If this was a PSHB Carrier then the naming convention would be:

the first sample would be saved as:
OPM AUP ReportsP UVWXYZ 6789A -1.xlsx

the second sample would be saved as:
OPM AUP ReportsP UVWXYZ 6789A -2.xlsx

Appendix E. Sample IPA Reports for Selected Requirements

1. Illustrative Report on Agreed-Upon Procedures (At Section 201.32)

United States Office of Personnel Management (OPM)
We have performed the procedures enumerated below, which were agreed to by the audit committee and management of (Carrier) and OPM solely to assist in evaluating the accompanying Annual Accounting Statement for the period ending XXXX. This agreed-upon procedure engagement was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. The sufficiency of these procedures is solely the responsibility of those specified in this report. Consequently, we make no representation regarding the sufficiency of the procedures described below, either for the purpose for which this report has been requested or for any other purpose.

The procedures we performed are enumerated in the listing of engagement procedures accompanying this report. Findings obtained from performing these procedures are presented in the accompanying Illustrative Schedule of Findings and Questioned Amounts.

We were not engaged to and did not conduct an examination, the objective of which would be the expression of an opinion on the accompanying Annual Accounting Statement of (Carrier). Accordingly, we do not express such an opinion. Had we performed additional procedures; other matters might have come to our attention that would have been reported to you.

This report is intended solely for the use of OPM and the audit committee and management of (Carrier) and is not intended to be and should not be used by anyone other than these specified parties. This restriction is not intended to limit the distribution of this report, which is a matter of public record.

2. Illustrative Schedule of Findings and Questioned Amounts

Note: IPA/Carrier must use the "Current & Prior Year Findings" tab in the OPM AUP Reports spreadsheet to report your findings and to document the status of all prior year findings.

Schedule of Findings for Agreed-Upon Procedures

AUP Section	Area	Date of Finding	Description of Findings	Type of Improper Payment	$ Questioned	$ Recovered/ Returned	Date Recovered/ Returned	Status of Finding
Health Benefits Charges	Claims Enrollment Records		Describe in detail the noted finding		$10,000 Unknown			1. Amount Has Been Credited to FEHB/PSHB Program, or 2. Amount Will Be Credited to FEHB/PSHB Program, or 3. Resolved – No Monies Due to FEHB/PSHB Program 4. Unresolved – To Be Determined Whether Monies are Due to FEHB/PSHB Program

3. Illustrative Comments on Resolution of Prior Year's Examination Findings

Note: IPA/Carrier must use the "Current & Prior Year Findings" tab in the OPM AUP Reports spreadsheet to report your findings and to document the status of all prior year findings.

For each Finding: In an examination performed by the (name of audit entity) dated (mm/dd/yyyy) and titled (name of report), in tests of claims paid, the Carrier did not properly coordinate payment of benefits. The FEHB/PSHB Program was overcharged by $xx.

Status: As of (mm/dd/yyyy) the Carrier has not reimbursed the FEHB/PSHB Program for these claims or recorded proper accounting entries to record payable to the FEHB/PSHB Program.

4. Illustrative Corrective Action Plan for Material Weaknesses or Findings

To ensure that deficiencies discovered during the audits discussed in this Guide are resolved, all Carriers must develop and submit to OPM a Corrective Action Plan (CAP).

A CAP, if applicable, is due to OPM by:

- **June 30, 2027,** for Calendar Year AUP Reporters
- **March 15, 2027,** for Fiscal Year AUP Reporters

The CAP is an essential part of a Carrier's annual reporting requirements. It must be presented on the Carrier's letterhead, signed by an appropriate Carrier official, include his or her title, and telephone number.

In the CAP, a Carrier's management must:

- Describe the corrective action taken or planned in response to findings identified in the IPA's report.
- Comment on the status of corrective action taken on the findings included in the IPA's two prior reports.

The CAPs are to be sent to the following email addresses:

- FEHBIP@opm.gov (FEHB and PSHB), with a copy to their OPM Contracting Officer.
- Ins-Carriers@opm.gov (FEHB)

or

- OCFO-PSHB@opm.gov (PSHB).

Please use the email subject line, “CAP Report – (Plan Name) and (Contract Number).”

Corrective Action Plan

(Prepared by Carrier)

Name of Carrier or service organization, plan code and contract number:

Official responsible for plan:

Phone number:

Audit Period:

IPA/Audit firm:

A. Comments on findings and recommendations

The Carrier is to provide a statement of concurrence or nonconcurrence with each finding and recommendation. For instances of nonconcurrence, the Carrier should provide documentation to support their position.

B. Actions taken or planned

The Carrier will develop a detailed action plan to correct or resolve all IPA findings. The plan should include expected correction date(s) and name of official responsible for corrective actions.

C. Categorize Actions taken or planned

For each type of improper payment (overpayment, underpayment, technically improper, unknown payment) identify the mitigation/corrective action strategy planned or taken, using this table. Enter "P" for action Planned or "T" for action Taken for each type of improper payment.

Mitigation Strategy Planned or Taken

Type of Improper Payment	Automation	Behavioral Sciences/ Psych Influence	Training	Change Process	Cross Enterprise Sharing	Audit	Predictive Analysis	Statutory Change
Overpayment								
Underpayment								
Technically Improper								

Type of Improper Payment	Automation	Behavioral Sciences/ Psych Influence	Training	Change Process	Cross Enterprise Sharing	Audit	Predictive Analysis	Statutory Change
Unknown Payment								

The definitions of the mitigation strategies are in the chart below.

Mitigation Strategy	Definition	Example
Automation	Automatically controlled operation, process, or system.	Automated interface between financial system and the system for award management; converting payments to electronic methods
Behavioral Sciences/Psych Influence	Uses principles from the behavioral sciences such as psychology, neuroscience, and behavioral economics to understand how individuals absorb, process, and react to information and applies this to design practical policies and interventions.	Changing the way options are ordered or presented helps reduce cognitive burden and enables individuals to make better choices
Training	Teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Refresher sessions; external trainings; mandatory annual trainings; prior authorization
Change Process	Altering or updating a process or policy to prevent or correct error.	Starting quality reviews; new pre-check list; policy update cycles

Mitigation Strategy	Definition	Example
Cross Enterprise Sharing	Sharing of documents, processes, and opportunities with intra-agency partners and stakeholder. Potentially managed through federated repositories and a registry to create a longitudinal connection to information used to mitigate IPs and Ups.	Workgroups; playbooks; cross-agency best practice sharing; pilots; data sharing
Audit	A process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations and policies.	Frequent reconciliations; access restrictions; passwords; exception reports
Predictive Analysis	A data analytics technique used to prevent IPs and Ups. It uses predictive capabilities to identify unobserved attributes that lead to suspicion of IPs and Ups based on known IPs. Predictive analytics is most effective if it is built after a program evolves through more standard capabilities that are also more cost-effective.	Automatically rejecting a payment when the existence of a number of known IP characteristics are present.
Statutory Change	Changes to statute that would change conditions giving rise to IPs or Ups.	

D. Status of corrective actions for prior year findings

The Carrier should document status of all prior year findings and the related corrective actions, including changes in corrective action and expected dates of completion