



United States Office of Personnel Management

Semiannual Report to Congress

**OFFICE OF THE
INSPECTOR GENERAL**

October 1, 2015 – March 31, 2016

OFFICE OF THE INSPECTOR GENERAL



Indicators

Financial Impact:

Audit Recommendations for Recovery of Funds	\$65,030,513
Management Commitments to Recover Funds	\$68,810,449
Recoveries Through Investigative Actions	\$8,202,207

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

Accomplishments:

Audit Reports Issued	31
Special Review Reports Issued	1
Evaluation Reports Issued	2
Investigative Cases Closed	38
Indictments and Informations	24
Arrests	13
Convictions	20
Hotline Contacts and Preliminary Inquiries Complaints Received	3,063
Hotline Contacts and Preliminary Inquiries Complaints Closed	2,576
Health Care Provider Debarments and Suspensions	376
Health Care Provider Debarment and Suspension Inquiries	2,342



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Message from the Acting Inspector General

On February 19, 2016, Patrick E. McFarland retired from Federal service after serving for more than 25 years as the Inspector General for the U.S. Office of Personnel Management (OPM).

He was nominated for this position by President George H.W. Bush on April 11, 1990, and confirmed by the Senate four months later, on August 10, 1990. When Inspector General McFarland arrived at the OPM Office of the Inspector General (OIG), it had fewer than 50 staff members, all of whom were located at OPM's headquarters in Washington, DC. At the time of his retirement, the staff had more than tripled in size and its geographic presence had expanded to include three field offices as well as 20 criminal investigators domiciled in 17 states across the country.



During his tenure, the OIG's Office of Audits issued almost 2,000 audit reports recommending the recovery of nearly \$2 billion in OPM funds. In addition, the work performed by the OIG's Office of Investigations resulted in over 770 convictions and returned approximately \$1 billion to OPM and its trust funds.

Inspector General McFarland also dedicated significant time and energy to pursuing legislative changes that would increase the OIG's effectiveness. He worked to achieve statutory debarment authority for OPM so that the agency could ensure that doctors and health care providers who break the law or have their licenses revoked cannot participate in the Federal Employees Health Benefits Program. Since that time, the OIG has debarred over 40,000 such providers. He also worked to amend Title 5 to authorize the OIG's access to OPM's Revolving Fund, allowing the office to significantly increase oversight of OPM's Federal Investigative Services, which is one of the agency's most critical programs.

(continued on next page)



Message from the Acting Inspector General

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Over the course of almost 26 years, Inspector General McFarland was an energetic contributor to the Inspector General community. He was an active member of the Council of the Inspectors General on Integrity and Efficiency (CIGIE), sitting on CIGIE's Professional Development Committee as well as the Integrity Committee, which is assigned the responsibility to investigate allegations of wrongdoing against Inspectors General and senior members of their staffs. Due to his extensive law enforcement experience, he also served several terms as the chair of CIGIE's Investigations Committee.

A little-known project that was dear to his heart brought together the Inspector General community and the National Center for Missing and Exploited Children (NCMEC). He worked hard to pass a legislative amendment that allows OIGs to provide specific types of investigative support to NCMEC. This endeavor culminated in the establishment of Project FIGHT, a program through which OIGs can work with NCMEC to reexamine cold cases in hopes of finally providing closure to long-suffering families.

Most importantly, however, Inspector General McFarland inspired admiration and dedication in his staff in a way that can never be matched. For almost 26 years, he was not only the leader of this organization, but also its heart. His integrity has been impeccable and he always led by example. It is an understatement to say he will be missed, but we will honor his legacy by continuing to strive for the highest professional and ethical standards, and by following his oft-stated credo – to know our business and responsibilities better than anyone else and at the end of the day, to be able to say we did what was right.

Norbert E. Vint
Acting Inspector General



Mission Statement

Our mission is to provide independent and objective oversight of OPM services and programs.

We accomplish our mission by:

- Conducting and supervising audits, evaluations, and investigations relating to the programs and operations of the U.S. Office of Personnel Management (OPM).
- Making recommendations that safeguard the integrity, efficiency, and effectiveness of OPM services.
- Enforcing laws and regulations that protect the program assets that are administered by OPM.

Guiding Principles

We are committed to:

- Promoting improvements in OPM's management and program operations.
- Protecting the investments of the American taxpayers, Federal employees and annuitants from waste, fraud, and mismanagement.
- Being accountable to the concerns and expectations of our stakeholders.
- Observing the highest standards of quality and integrity in our operations.

Strategic Objectives

The Office of the Inspector General will:

- Combat fraud, waste and abuse in programs administered by OPM.
- Ensure that OPM is following best business practices by operating in an effective and efficient manner.
- Determine whether OPM complies with applicable Federal regulations, policies, and laws.
- Ensure that insurance carriers and other service providers for OPM program areas are compliant with contracts, laws, and regulations.
- Aggressively pursue the prosecution of illegal violations affecting OPM programs.
- Identify, through proactive initiatives, areas of concern that could strengthen the operations and programs administered by OPM.



Table of Contents

Productivity Indicators	Inside Cover
Message from the Acting Inspector General	i
Mission Statement	iii
Field Offices	vii
Audit Activities	1
Health Insurance Carrier Audits	1
Information Systems Audits	10
Internal Audits	16
Special Audits	20
Enforcement Activities	23
Investigative Cases	23
Administrative Sanctions of FEHBP Health Care Providers	34
Evaluations and Inspections Activities	37
Statistical Summary of Enforcement Activities	39
Appendix I - A:	
Final Reports Issued With Questioned Costs for Insurance Programs	41
Appendix I - B:	
Final Reports Issued With Recommendations for All Other Audit Entities	42
Appendix II:	
Final Reports Issued With Recommendations for Better Use of Funds	42
Appendix III:	
Insurance Audit Reports Issued	43

(continued on next page)



Table of Contents

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Appendix IV:

Internal Audit Reports Issued.45

Appendix V:

Information Systems Audit Reports Issued45

Appendix VI:

Special Review Reports Issued.46

Appendix VII:

Evaluations and Inspections Reports Issued46

Appendix VIII:

Summary of Reports More Than Six Months Old Pending Corrective Action.47

Appendix IX:

Most Recent Peer Review Results52

Appendix X:

Investigative Recoveries.53

Index of Reporting Requirements54



Field Offices





Audit Activities

Health Insurance Carrier Audits

The United States Office of Personnel Management (OPM) contracts with private sector firms to provide health insurance through the Federal Employees Health Benefits Program (FEHBP), as well as through the marketplaces under the Affordable Care Act. Our office is responsible for auditing the activities of these programs to ensure that the insurance carriers meet their contractual obligations with OPM.

The Office of the Inspector General's (OIG) insurance audit universe contains approximately 275 audit sites, consisting of health insurance carriers, sponsors, and underwriting organizations. The number of audit sites is subject to yearly fluctuations due to the addition of new carriers, non-renewal of existing carriers, or health insurance carrier mergers and acquisitions. The premium payments for these health insurance programs are over \$49.9 billion annually.

The health insurance plans that our office audits are either community-rated or experience-rated carriers.

Community-rated carriers are comprehensive medical plans, commonly referred to as health maintenance organizations (HMOs) or health plans.

Experience-rated carriers are mostly fee-for-service plans, the largest being the BlueCross and BlueShield health plans, but also include experience-rated HMOs.

Community-rated and experience-rated carriers differ in the level of risk each type of carrier assumes. Community-rated carriers must pay claims and cover its costs from the premiums it receives each year. If the premiums are not sufficient to cover the costs, the community-rated carrier suffers the loss. Experience-rated carriers request reimbursement for actual claims paid, administrative expenses incurred, and service charges for administering a specific contract from the Letter-of-Credit account, which is not solely dependent on total premiums paid to the carrier during the year.

During the current reporting period, we issued 22 final audit reports on organizations participating in the FEHBP, of which 14 contain recommendations for monetary adjustments in the amount of \$65 million due to the OPM-administered trust funds.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

COMMUNITY-RATED PLANS

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

Similarly Sized Subscriber Group Audits

Federal regulations require that the FEHBP rates be equivalent to the rates a health plan charges the two employer groups closest in subscriber size, commonly referred to as *similarly sized subscriber groups* (SSSGs). The rates are set by the health plan, which is also responsible for selecting the SSSGs. When an audit shows that the rates are not equivalent, the FEHBP is entitled to a downward rate adjustment to compensate for any overcharges.

Similarly sized subscriber group audits of traditional community-rated carriers focus on ensuring that:

- The health plans select the appropriate SSSGs;
- The FEHBP rates are equivalent to those charged to the SSSGs; and,
- The loadings applied to the FEHBP rates are appropriate and reasonable.

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

Medical Loss Ratio Audits

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

Medical Loss Ratio (MLR) is the proportion of health insurance premiums collected by a health insurer that is spent on clinical services and

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

The FEHBP-specific MLR rules are based on the MLR standards established by the Affordable Care Act. In 2012, community-rated FEHBP carriers could elect to follow the FEHBP-specific MLR requirements, instead of the SSSG requirements. Beginning in 2013, the MLR methodology was required for all community-rated carriers, except those that are state mandated to use traditional community rating. State mandated traditional community rating carriers continue to be subject to the SSSG comparison rating methodology.

Starting with the pilot program in 2012 and for all non-traditional community rating FEHBP carriers in 2013, OPM required the carriers to submit an FEHBP-specific MLR. The FEHBP-specific MLR required carriers to report information related to earned premiums and expenditures in various categories, including reimbursement for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. If a carrier fails to meet the FEHBP-specific MLR threshold, it must make a subsidization penalty payment to OPM within 60 days of notification of amounts due. Since the claims cost is a major factor in the MLR calculation, we are now focusing our efforts on auditing the FEHBP claims used in the MLR calculation.

Multi-State Plan Program Audits

The Multi-State Plan Program (MSPP) was established by Section 1334 of the Affordable Care Act. Under the Affordable Care Act, OPM was directed to contract with private health insurers to offer Multi-State Plan (MSP) products in each state and the District of Columbia. OPM negotiates contracts with MSP Program Issuers, including rates and benefits, in consul-

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



tation with states and marketplaces.

In addition, OPM monitors the performance of MSP Program Issuers and oversees compliance with legal requirements and contractual terms. OPM's office of National Healthcare Operations has overall responsibility for program administration. Currently, the MSPP universe consists of approximately 40 state-level issuers covering 32 states and the District of Columbia. Our audits of this program test the issuer's compliance with the provisions of its contract with OPM as well as with other applicable Federal regulations.

During this reporting period, we issued 10 final audit reports on community-rated health plans and MSP issuers and recommended approximately \$12 million in premium recoveries to the FEHBP. Report summaries are provided below to highlight notable audit findings.

Humana Benefit Plan of Illinois, Inc.

LOUISVILLE, KENTUCKY

Report No. 1C-9F-00-15-010

OCTOBER 28, 2015

The Humana Benefit Plan of Illinois, Inc. (Plan) has participated in the FEHBP since 1998, and provides health benefits to FEHBP members in the Central and Northwestern Illinois areas. The audit covered contract years 2010 through 2012. During this period, the FEHBP paid the Plan approximately \$26 million in premiums.

In 2010, we identified inappropriate health benefit charges to the FEHBP totaling \$326,013. In addition, we determined the FEHBP is due \$36,982 for lost investment income as a result of the overcharges.

Lost investment income (LII) represents the potential interest earned on the amount the plan overcharged the FEHBP as a result of defective pricing.

The overcharges occurred due to the Plan:

- Not applying the largest SSSG discount to the 2010 FEHBP rates;
- Using incorrect capitation amounts in its 2010 FEHBP rate development; and,
- Not accounting for benefit changes in the FEHBP's 2010 claims experience.

**Inappropriate
Charges
Amount to
\$362,995**

Humana agreed with some of the audit findings and returned a portion of the amount questioned in December 2015. However, the audit remains open pending the return of the remaining amounts questioned or the provision of documentation that would support the open audit issues.

MD-Individual Practice Association, Inc.

CYPRESS, CALIFORNIA

Report No. 1C-JP-00-15-035

FEBRUARY 26, 2016

The MD-Individual Practice Association, Inc. (Plan) has participated in the FEHBP since 1983, and provides health benefits to FEHBP members in the Washington, D.C., Maryland, Northern Virginia, and Richmond, Virginia areas. The audit covered the Plan's 2013 FEHBP premium rate build-up and MLR submissions. During this period, the FEHBP paid the Plan approximately \$435 million in premiums.

Our auditors questioned \$11,363,178 for inappropriate health benefit charges to the FEHBP.

Specifically, we found that the Plan:

- Could not support the capitation amounts, other claim adjustment amounts, and the Patient-Centered Outcomes Research Institute fee in



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

its MLR calculation, resulting in a subsidization penalty underpayment of \$11,363,178;

- Did not provide claims data to the OIG in accordance with Carrier Letter 2014-18; and,
- Was not in compliance with its contract with OPM as it failed to provide requested data in a timely manner, or at all in some cases. The Plan also restricted our access to subject matter experts who could have addressed our questions.

**Insufficient
Documentation
Results in
an MLR
Underpayment
of \$11,363,178**

The Plan disagreed with most of the audit findings. This audit is still in the process of being resolved.

Dean Health Plan

MADISON, WISCONSIN

Report No. 1C-WD-00-15-039

MARCH 28, 2016

Dean Health Plan (Plan) has participated in the FEHBP since 1985, and provides health benefits to FEHBP members in south central Wisconsin. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-ups and MLR submissions. During this period, the FEHBP paid the Plan approximately \$98 million in premiums.

Our auditors identified the following issues related to the 2013 MLR submission. The Plan:

- Did not use the correct claims data in the MLR calculation and did not reduce the incurred claims totals by the change in health care receivables;

**MLR Calculation
Errors Result
in an
Overstatement
of \$537,762**

- Incorrectly included taxes on investment income; and,
- Did not use the correct premium income amounts.

Consequently, the audit questioned \$537,762 for the Plan's overstatement of its 2013 MLR credit.

The Plan agreed with some issues and disagreed with others. This audit is still in the process of being resolved.

BlueCross and BlueShield of Michigan

DETROIT, MICHIGAN

Report No. 1M-OC-00-15-052

FEBRUARY 16, 2016

The BlueCross BlueShield Association, on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a contract with OPM to participate in the MSPP. In accordance with requirements for the first year of the MSPP contract, participating plans offered 154 Multi-State Plan (MSP) options in 30 states and the District of Columbia. BCBS of Michigan was 1 of 35 BCBS plans, or State-level issuers, participating in the MSPP in 2014.

BCBS of Michigan is a nonprofit mutual insurance company and is an independent licensee of the Association. As of 2015, it was providing coverage to 22,400 through the ACA Marketplace Exchanges. This audit covered BCBS of Michigan's compliance with the provisions of its Contract with OPM, as well as with other applicable Federal regulations for contract year 2014.

The audit disclosed no findings.

EXPERIENCE-RATED PLANS

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

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



experience-rated HMOs fall into this category. The universe of experience-rated plans currently consists of approximately 100 audit sites. When auditing these plans, our auditors generally focus on three key areas:

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

During this reporting period, we issued eight experience-rated final audit reports. In these reports, our auditors recommended that the plans return \$52 million in inappropriate charges and lost investment income to the FEHBP.

BlueCross Blueshield Service Benefit Plan

The BlueCross BlueShield Association (Association), on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a Government-wide Service Benefit Plan with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its Federal subscribers.

The Association has established a Federal Employee Program (FEP) Director's Office, in Washington, D.C., to provide centralized management for the Service Benefit Plan. The FEP Director's Office coordinates the administration of the contract with the Association, BCBS plans, and OPM. The Association has also established an FEP Operations Center. The activities of the FEP Operations Center are performed by CareFirst BlueCross BlueShield, located in Washington, D.C. These activities include acting as fiscal intermediary between the Association

and member plans, verifying subscriber eligibility, approving or disapproving the reimbursement of local plan payments of FEHBP claims, maintaining a history file of all FEHBP claims, and an overall accounting for all program funds.

The Association, which administers a fee-for-service plan known as the Service Benefit Plan, contracts with OPM on behalf of its member plans throughout the United States. The participating plans independently underwrite and process the health benefits claims of their respective Federal subscribers and report their activities to the national BCBS operations center in Washington, D.C. Approximately 64 percent of all FEHBP subscribers are enrolled in BCBS plans.

We issued six BCBS experience-rated reports during the reporting period. Experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, cash management activities, and/or Fraud and Abuse Program activities. Our auditors identified \$50 million in questionable costs charged to the FEHBP contract. Summaries of three of these final reports are provided below to highlight our notable audit findings.

CareFirst BlueCross BlueShield

OWINGS MILLS, MARYLAND

Report No. 1A-10-85-14-053

OCTOBER 28, 2015

CareFirst BlueCross BlueShield (Plan) includes the BCBS plans of the Washington, D.C. and Maryland Service Areas. For contract years 2009 through 2013, the Plan processed approximately \$9 billion in FEHBP health benefit payments and charged the FEHBP \$531 million in administrative expenses for the Washington, DC and Maryland Service Areas.

Our audit of the FEHBP operations at CareFirst BCBS covered miscellaneous health benefit payments and administrative expenses from 2009 through 2013



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

for the Plan's DC and Maryland Service Areas. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2009 through 2013, as well as the Plan's Fraud and Abuse Program from 2013 through June 2014.

We questioned \$657,472 in health benefit charges, administrative expenses, and lost investment income (LII). The monetary findings included the following:

- \$595,303 for unreturned health benefit refunds and recoveries and medical drug rebates as well as \$127,642 for LII on health benefit refunds and recoveries, medical drug rebates, special plan invoice amounts, and fraud and abuse recoveries returned untimely to the FEHBP;
- \$138,115 for administrative expense overcharges and \$3,625 for applicable LII on these overcharges; and,
- \$207,213 for administrative expense undercharges.

**Auditors Question
\$657,472 in
Health Benefit
Charges,
Administrative
Expenses, and
Lost Investment
Income**

The Association and Plan agreed with all of these questioned amounts.

Regarding the Plan's cash management activities and practices, we determined that CareFirst BCBS handled FEHBP funds in accordance with the FEHBP contract and applicable laws and regulations concerning cash management in the FEHBP. Our auditors also identified no findings pertaining to the Plan's Fraud and Abuse Program. Overall, we concluded that CareFirst BCBS is in compliance with the communication and reporting requirements for fraud and abuse cases that are contained in the FEHBP contract and the applicable FEHBP Carrier Letters.

Focused Audit of Pension and Post-Retirement Benefit Costs Sample of BlueCross and BlueShield Plans

Report No. 1A-99-00-14-068

NOVEMBER 16, 2015

Our focused audit covered the plan employee pension and post-retirement benefit costs that were charged to the FEHBP from 2011 through 2013 for a sample of 24 BCBS plans (from a universe of 64 plans). Our sample included all BCBS plans with total FEHBP charges of \$350 million or less in contract year 2013 (except for several BCBS plans that are part of multi-plan companies, such as Anthem Inc.). For contract years 2011 through 2013, these 24 BCBS plans charged \$21.7 million and \$5.5 million to the FEHBP for the plan employee pension and post-retirement benefit costs, respectively.

**Plan Employee
Pension and
Post-Retirement
Benefit Cost
Result in
\$115,126 in
Overcharges**

The objective of our audit was to determine whether the 24 BCBS plans in our sample charged plan employee pension and post-retirement benefit costs to the FEHBP in accordance with the terms of the contract and applicable regulations. Our auditors determined that two BCBS plans overcharged the FEHBP \$10,399 for plan employee pension costs and one BCBS plan overcharged the FEHBP \$104,727 for plan employee post-retirement benefit costs.

The Association and applicable BCBS plans agreed with these questioned charges of \$115,126. Additionally, lost investment income on the questioned charges totaled \$4,040.



BlueCross BlueShield of Minnesota

EAGAN, MINNESOTA

Report No. 1A-10-78-15-040

FEBRUARY 16, 2016

Our audit of the FEHBP operations at BlueCross BlueShield of Minnesota (Plan) covered miscellaneous health benefit payments and credits from 2010 through September 2014, as well as administrative expenses from 2009 through 2013. In addition, we reviewed the Plan's cash management activities and practices related to FEHBP funds from 2010 through September 2014 and the Plan's Fraud and Abuse Program from January 2014 through September 2014. For contract years 2009 through 2013, the Plan processed approximately \$1.7 billion in FEHBP health benefit payments and charged the FEHBP \$87.5 million in administrative expenses.

We questioned \$227,123 in health benefit refunds and recoveries, medical drug rebates, and lost investment income (LII). Our auditors also identified a procedural finding regarding the Plan's Fraud and Abuse Program. The monetary findings included the following:

- \$186,314 for unreturned health benefit refunds and \$17,446 for applicable LII on these refunds; and,
- \$22,028 for unreturned medical drug rebates and \$1,335 for applicable LII on these rebates.

For the procedural finding regarding the Plan's Fraud and Abuse Program, we determined that the Plan and FEP Director's Office are not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters. Specifically, the Plan and FEP Director's Office did not report, or report timely, all fraud and abuse cases to OPM's OIG. This non-compliance may be due in part to:

- Incomplete and/or untimely reporting of fraud and abuse cases to the FEP Director's Office by the Plan; and,
- Inadequate controls at the FEP Director's Office to monitor and communicate the Plan's cases to us.

Without awareness of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.

The Association and Plan agreed with the questioned amounts and the procedural finding.

**Auditors Question
\$227,123 in
Health Benefit
Refunds and
Recoveries,
Medical Drug
Rebates, and
Lost Investment
Income**

EMPLOYEE ORGANIZATION PLANS

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

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

We issued one report on an employee organization during this reporting period, which is highlighted below.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

National Rural Letter Carriers' Association

ALEXANDRIA, VIRGINIA

Report No. 1B-38-00-15-057

FEBRUARY 26, 2016

The National Rural Letter Carriers' Association (NRLCA) is the sponsor and administrator of the Rural Carrier Benefit Plan (Plan). The Plan is a fee-for-service experience-rated employee organization plan offering health care benefits to eligible enrollees and their families. Plan enrollment is open to eligible active and retired rural letter carriers of the United States Postal Service. To enroll in the Plan, you must already be, or must immediately become, a member of the NRLCA.

NRLCA's activities include overall administrative management of the Plan, determining eligibility for the Plan, and administering the general day-to-day operations of the Plan. Our audit covered NRLCA's administrative expenses that were charged to the FEHBP from 2010 through 2014. During this period, NRLCA charged approximately \$9.2 million in administrative expenses to the FEHBP.

The specific objective of our audit was to determine whether NRLCA charged administrative expenses to the FEHBP that were actual, allowable, necessary, and reasonable expenses

incurred in accordance with the terms of the FEHBP contract and applicable regulations. As a result of our audit, we questioned \$11,903 in net administrative expense overcharges and applicable LII. The monetary findings included the following:

- \$5,262 in net overcharges for self-disclosed cost adjustments;

- \$3,933 for administrative expenses that were unallowable and/or did not benefit the FEHBP, such as holiday parties and airline club memberships;
- \$1,410 for excessive benefit plan brochure printing costs; and,
- \$1,298 for applicable LII on the questioned overcharges.

NRLCA agreed with all of these questioned amounts.

EXPERIENCE-RATED COMPREHENSIVE MEDICAL PLANS

Comprehensive medical plans fall into one of two categories: community-rated or experience-rated. As we previously explained on page 1 of this report, the key difference between the categories stems from how premium rates are calculated.

Members of experience-rated plans have the option of using a designated network of providers or using out-of-network providers. A member's choice in selecting one health care provider over another has monetary and medical implications. For example, if a member chooses an out-of-network provider, the member will pay a substantial portion of the charges and covered benefits may be less comprehensive.

We issued one experience-rated comprehensive medical plan audit report during this reporting period, which is highlighted below.

**Auditors Question
\$11,903 in
Administrative
Expenses and
Lost Investment
Income**

KPS Health Plans

SEATTLE, WASHINGTON

Report No. 1D-VT-00-15-026

FEBRUARY 2, 2016

The KPS Health Plans' (Plan) offices are located in Bremerton and Seattle, Washington. Since 2005, the Plan has operated as a wholly owned subsidiary of Group Health Cooperative, which is headquartered in Seattle, Washington.

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



The Plan is an experience-rated HMO offering High Option, Standard Option, and High Deductible plans to Federal enrollees and their families. Plan enrollment is open to all Federal employees and their families working or residing in the state of Washington.

The audit of the Plan's FEHBP operations covered miscellaneous health benefit payments and credits, such as refunds and pharmacy drug rebates, from 2010 through 2014. We also reviewed the Plan's cash management activities and practices related to FEHBP funds from 2010 through March 2015, and the Plan's Fraud and Abuse Program for 2014. For contract years 2010 through 2014, the Plan processed approximately \$371 million in FEHBP health benefit payments and charged the FEHBP \$34 million in administrative expenses.

We questioned \$2,028,790 in health benefit refunds and recoveries, pharmacy drug rebates, cash management activities, and LII; and our auditors identified a procedural finding regarding the Plan's Fraud and Abuse Program. The monetary findings included the following:

- \$1,149,634 in excess FEHBP funds held by the Plan in the dedicated FEHBP investment account as of March 31, 2015;
- \$741,856 for unreturned health benefit refunds and recoveries and pharmacy drug rebates;

- \$122,060 for LII on health benefit refunds and recoveries and pharmacy drug rebates returned untimely to the FEHBP; and,
- \$15,240 for unreturned investment income earned on funds held in the dedicated FEHBP investment account from 2010 through 2014.

**KPS Health
Plans Returned
Over \$2 Million
in Questioned
Amounts to the
FEHBP**

For the procedural finding regarding the Plan's Fraud and Abuse Program, we determined that the Plan is not in compliance with the communication and reporting requirements for fraud and abuse cases contained in the FEHBP contract and the applicable FEHBP Carrier Letters. Specifically, the Plan did not report, or report timely, all fraud and abuse cases to OPM's OIG. Without notification of the Plan's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP. This non-compliance may be due, in part, to the Plan downsizing the Special Investigations Unit and only having one investigator during the audit scope. In our opinion, by having only one investigator for the entire company, the Plan's Fraud and Abuse Program is not as effective as this program should be.

The Plan agreed with our audit findings and returned all of the questioned amounts to the FEHBP. In 2015, the Plan also hired an additional investigator for the Special Investigations Unit.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems assist in the management of background investigations for Federal employees, the processing of retirement benefits, and multiple Government-wide human resources services. OPM also contracts with private industry health insurance carriers to administer programs that distribute health benefits to millions of current and former Federal employees. The increasing frequency and sophistication of cyber-attacks on both the private and public sector emphasizes the need for OPM and its contractors to implement and maintain effective cybersecurity programs. Our information technology audits outline areas for improvement in their cybersecurity posture and our recommendations provide tangible strategies to remediate identified weaknesses.

Our audit universe encompasses all OPM owned information systems as well as the information systems used by any private sector entity that contracts with OPM to process Federal data. In addition, our auditors evaluate historical health benefit claims data for appropriateness, and make audit recommendations that erroneous payments be returned to OPM.

Summaries of some of the audit reports issued during this period are provided below.

Information System General and Application Controls at Special Agents Mutual Benefit Association

ROCKVILLE, MARYLAND

Report No. 1B-44-00-14-065

OCTOBER 28, 2015

Our information technology (IT) audit focused on the claims processing applications used to adjudicate FEHBP claims for Special Agents Mutual Benefit Association (SAMBA) members, as well as the various processes and IT systems used to support these applications.

On January 29, 2015, we issued a Flash Audit Alert to bring to OPM's immediate attention serious concerns we had regarding SAMBA's ability to adequately secure sensitive Federal data. The Flash Audit Alert contained three recommendations related to inadequate IT policies and procedures and critical security vulnerabilities on SAMBA's computer servers. We subsequently issued a final audit report that documented the controls in place and opportunities for improvement in each of the areas below.

Security Management

We noted several areas of concern related to SAMBA's network security controls:

- Several critical IT security policies and procedures have not been created.
- Routine risk assessments are not conducted.
- The background investigation process could be improved.
- Training requirements for employees with specialized IT security responsibilities have not been established.

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



Access Controls

We noted several areas of concern related to SAMBA's access controls:

- Facility physical access controls could be improved;
- Physical access auditing does not routinely occur; and,
- Employee or privileged user access activity is not monitored.

Network Security

We noted several areas of concern related to SAMBA's network security controls:

- A firewall configuration/hardening policy has not been developed;
- Firewall settings are not routinely audited;
- A process to log security-related network events and an automated intrusion detection/prevention system have not been implemented;
- Controls to encrypt user workstation hard drives and removable media devices have not been implemented; and,
- A vulnerability scanning and remediation process to identify system weaknesses and ensure the timely application of security patches and fixes has not been implemented.

Configuration Management

SAMBA has not developed formal configuration policies/baselines for all operating platforms used in its environment. Furthermore, SAMBA does not audit its operating platforms' configuration against documented baseline configurations.

Contingency Planning

SAMBA has established an enterprise level business continuity plan in the event of a disaster or disrupting event. However, SAMBA has not yet documented detailed procedures to supplement the business continuity plan. SAMBA also has not completed a functional test of its business continuity plan.

Claims Adjudication

SAMBA has implemented several controls in its claims adjudication process to ensure that FEHBP claims are processed accurately. However, we noted weaknesses in SAMBA's claims application controls.

In the time since the Flash Audit Alert and final audit report were issued, SAMBA has made significant progress in improving its IT security posture and has already implemented most of the recommendations issued in those reports.

**SAMBA Makes
Significant
Improvements after
Implementing Audit
Recommendations**

Federal Information Security Modernization Act

WASHINGTON, D.C.

Report No. 4A-CI-00-15-011

NOVEMBER 10, 2015

The Federal Information Security Modernization Act of 2014 (FISMA) is designed to ensure that the information systems and data supporting Federal operations are adequately protected. The Act emphasizes that agencies implement security planning as part of the life cycle of their information systems. A critical aspect of security planning involves annual program security reviews conducted or overseen by each agency's inspector general.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

We audited OPM's compliance with FISMA requirements defined in the Office of Management and Budget's fiscal year (FY) 2015 Inspector General Federal Information Security Modernization Act Reporting Metrics. Over the past several years, the Office of the Chief Information Officer (OCIO) made noteworthy improvements to OPM's IT security program. However, some problem areas that had improved in past years have resurfaced.

In FY 2015, OPM was the victim of a massive data breach that involved the theft of sensitive personal information of millions of individuals. For many years we have reported critical weaknesses in OPM's ability to securely manage its IT environment, and warned that the agency was at an increased risk of a data breach. In the wake of this data breach, OPM is finally focusing its efforts on improving its IT security posture. Unfortunately, as indicated by the variety of findings in this audit report, OPM continues to struggle to meet many FISMA requirements.

During this audit we did close a long-standing recommendation related to OPM's information security management structure. However, this audit also determined that there has been a regression in OPM's management of its system Authorization program, which we classified as a material weakness in the FY 2014 FISMA audit report. In April 2015, the Chief Information Officer issued a memorandum that granted an extension of the previous Authorizations for all systems whose Authorization had already expired, and for those scheduled to expire through September 2016. Should this moratorium on Authorizations continue, the agency will have up to 23 systems that have not been subject to a thorough security controls assessment.

We continue to believe that OPM's management of system Authorizations represents a material weakness in the internal control structure of the agency's IT security program. The moratorium on Authorizations will result in the IT security controls of OPM's systems being neglected. Combined with the inadequacy and non-compliance of OPM's continuous monitoring

program, we are very concerned that the agency's systems will not be protected against another attack.

Additionally, OPM's inability to accurately inventory its systems and network devices drastically diminishes the effectiveness of its security controls. OPM has implemented a large number of improved security monitoring tools, but without a complete understanding of its network, it cannot adequately monitor its environment and therefore the usefulness of these tools is reduced.

In addition, we documented the following opportunities for improvement:

- OPM's system development life cycle policy is not enforced for all system development projects.
- OPM does not maintain a comprehensive inventory of servers, databases, and network devices.
- OPM does not have a mature continuous monitoring program. Also, security controls for all OPM systems are not adequately tested in accordance with OPM policy.
- The OCIO has implemented an agency-wide information system configuration management policy; however, configuration baselines have not been created for all operating platforms. Also, all operating platforms are not routinely scanned for compliance with configuration baselines.
- We are unable to independently attest that OPM has a mature vulnerability scanning program.
- Multi-factor authentication is not required to access OPM systems in accordance with OMB memorandum M-11-11.
- OPM has not fully established a Risk Executive Function.
- Many individuals with significant information security responsibility have not taken specialized security training in accordance with OPM policy.



- Program offices are not adequately incorporating known weaknesses into Plans of Action and Milestones (POA&M) and the majority of systems contain POA&Ms that are over 120 days overdue.
- OPM has not configured its virtual private network servers to automatically terminate remote sessions in accordance with agency policy.
- Not all OPM systems had their contingency plans reviewed or had contingency plan tests conducted in FY 2015.
- Several information security agreements between OPM and contractor-operated information systems have expired.

OPM Struggles to Meet FISMA Requirements; New Material Weaknesses Added

In the time since this audit report was issued OPM has ended its moratorium on Authorizations. As of March 31, 2016, OPM has developed a new streamlined Authorization process, and is in the early stages of assessing the security controls of all information systems operating without a valid Authorization. We will continue to closely monitor the agency's progress in addressing this material weakness.

Health Care Service Corporation Claims

CHICAGO, ILLINOIS

Report No. 1A-10-17-14-037

NOVEMBER 19, 2015

Health Care Service Corporation (HCSC) processes insurance claims for BlueCross and BlueShield FEHBP members in five states (Illinois, Montana, New Mexico, Oklahoma, and Texas). The objective of our audit was to determine whether HCSC appropriately charged costs to the FEHBP in

accordance with BCBS Association's contract with OPM. From 2011 through 2014, HCSC paid approximately \$10.6 billion in health benefits claims. We reviewed \$81.5 million of these claims payments.

We found that HCSC incorrectly paid over \$35 million in improper health benefit claims by paying FEHBP claims at an unreasonably high rate to the U.S. Department of Veterans Affairs (VA) medical providers.

Based on various criteria, HCSC had the option to pay VA claims using one of the following three methods:

- Pay the full amount billed by the VA medical providers;
- Pay the lower non-participating provider allowance paid to providers that are not part of HCSC's provider network ("non-par" rates); or,
- Pay a lower rate negotiated with the VA medical providers.

For two of the five states that HCSC services, HCSC made the most cost effective choice and contracted with VA providers using negotiated pricing allowances. For the remaining three service areas, HCSC had the same option to pay at a lower rate, but instead deliberately forced these claims to pay at the highest possible option of full billed charges.

In our opinion, it appears that HCSC did not practice good judgement or provide proper oversight for payments made to VA medical providers on behalf of the FEHBP. As a result, the FEHBP was overcharged substantially for claim expenses, and FEHBP members faced an average 60 percent increase in their out-of-pocket expenses.

HCSC Overcharged FEHBP \$35 Million in Improper Claim Payments



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

HCSC is a third-party administrator for the FEHBP, meaning that all claims expenses and the associated administrative costs are drawn from the Federal FEHBP trust fund, as opposed to HCSC's commercial funds. The Plan assumes minimal risk while acting as a third-party administrator for the FEHBP. We do not believe that any competitive business would unnecessarily pay these claims at a higher rate if the funds were exclusively paid from its commercial lines of business, as opposed to Federal money that it does not have the same vested interest in protecting.

Information System General and Application Controls at KeyPoint Government Solutions

LOVELAND, COLORADO

Report No. 4A-IS-00-15-034

DECEMBER 9, 2015

OPM contracts with KeyPoint Government Solutions (KeyPoint) to support the agency's Federal Investigative Services (FIS) background investigation program, which is responsible for helping to ensure that the Federal Government has a workforce that is worthy of the public trust by providing both suitability and security clearance determinations. KeyPoint's primary role for OPM is to conduct background investigation fieldwork to collect data used in the clearance determination process.

We performed an information technology audit focused on the KeyPoint information systems that process and/or store Federal data, as well as the various processes and IT systems used to support these systems.

We documented the controls in place and opportunities for improvement in each of the areas below.

Security Management

KeyPoint has implemented a security management program with adequate IT security policies and procedures.

Access Controls

KeyPoint has implemented controls to prevent unauthorized physical access to its facilities, as well as logical controls to protect sensitive information. However, we noted several opportunities for improvement related to KeyPoint's access controls:

- Standardized access request forms are not utilized for managing information systems access.
- There is no formal process for auditing logical and physical access privileges.
- There are no formal procedures for reviewing system logs.

Network Security

KeyPoint has implemented an incident response and network security program. However, we noted several areas of concern related to KeyPoint's network security controls:

- A firewall configuration standard has not been developed.
- An outbound web proxy has not been implemented.
- Controls are not in place to prevent unauthorized devices from connecting to the network and control the use of removable media.
- Significant improvements are needed to the vulnerability management program.
- A methodology is not in place to ensure that unsupported or out-of-date software is not utilized.

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



- Several vulnerabilities with known exploits were identified as a result of our independent vulnerability scans.

Configuration Management

KeyPoint has implemented a configuration management process to control changes made to its IT systems. However, there is no routine auditing of KeyPoint's server and workstation configuration.

Contingency Planning

KeyPoint has documented contingency procedures that detail the recovery of servers in the event that normal service is disrupted. However, the contingency plan for workstations may not be feasible since it relies on a 3rd party without a service contract.

Application Controls

KeyPoint has implemented multiple controls surrounding the input, processing, and output of sensitive data related to the background investigations it performs for OPM. However, KeyPoint is provided more sensitive data from OPM than it needs to perform its contractual obligations.

OPM concurred with all but one of the recommendations, and partially concurred with the remaining recommendation. OPM is actively engaged in closing out the recommendations.

**Security Controls
are Compliant;
However,
Several Areas
for Improvement
Noted for
KeyPoint**



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Internal Audits

Our internal auditing staff focuses on improving the efficiency and effectiveness of OPM's operations and their corresponding internal controls. One critical area of this activity is the audit of OPM's consolidated financial statements required under the Chief Financial Officers Act (CFO) of 1990. Our staff also conducts performance audits covering other internal OPM programs and functions.

OPM'S CONSOLIDATED FINANCIAL STATEMENTS AUDITS

The CFO Act requires that audits of OPM's financial statements be conducted in accordance with Government Auditing Standards issued by the Comptroller General of the United States. OPM contracted with the independent certified public accounting firm KPMG LLP (KPMG) to audit the consolidated financial statements as of September 30, 2015 and for the fiscal year (FY) then ended.

The contract requires that the audit be performed in accordance with generally accepted government auditing standards (GAGAS) and the OMB Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, as amended.

OPM's consolidated financial statements include the Retirement Program, Health Benefits Program, Life Insurance Program, Revolving Fund Programs (RF), and Salaries and Expenses funds (S&E). The RF programs provide funding for a variety of human resource-related services to other Federal agencies, such as: pre-employment testing, background investigations, and employee training. The S&E funds provide the resources used by OPM for the administrative costs of the agency.

KPMG's responsibilities include, but are not limited to, issuing an audit report with:

- Opinions on the consolidated financial statements and the individual statements for the three benefit programs;

- A report on internal controls; and,
- A report on compliance with certain laws and regulations.

In connection with the audit contract, we oversee KPMG's performance of the audit to ensure that it is conducted in accordance with the terms of the contract and is in compliance with GAGAS and other authoritative references.

Specifically, we were involved in the planning, performance, and reporting phases of the audit through participation in key meetings, reviewing KPMG's work papers, and coordinating the issuance of audit reports. Our review disclosed no instances where KPMG did not comply, in all material respects, with GAGAS, the contract, and all other authoritative references.

In addition to the consolidated financial statements, KPMG performed the audit of the closing package financial statements as of September 30, 2015 and 2014. The contract requires that the audit be done in accordance with GAGAS and OMB Bulletin No. 15-02, *Audit Requirements for Federal Financial Statements*, as amended. The U.S. Department of the Treasury and the Government Accountability Office use the closing package in preparing and auditing the *Financial Report of the United States Government*.



OPM's FY 2015 Consolidated Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-15-027

NOVEMBER 13, 2015

KPMG audited OPM's balance sheets as of September 30, 2015 and 2014 and the related consolidated financial statements. KPMG also audited the individual balance sheets of the Retirement, Health Benefits and Life Insurance programs (hereafter referred to as the Programs), as of September 30, 2015 and 2014 and the Programs' related individual financial statements for those years. The Programs, which are essential to the payment of benefits to Federal civilian employees, annuitants, and their respective dependents, operate under the following names:

- Civil Service Retirement System;
- Federal Employees Retirement System;
- Federal Employees Health Benefits Program (FEHBP); and,
- Federal Employees' Life Insurance Program.

KPMG reported that OPM's consolidated financial statements and the Programs' individual financial statements as of and for the years ending September 30, 2015 and 2014, were presented fairly, in all material respects, in conformity with U.S. generally accepted accounting principles. KPMG's audits generally include identifying internal control deficiencies, significant deficiencies, and material weaknesses.

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

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

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

KPMG identified one material weakness and one significant deficiency in internal controls. The areas identified by KPMG are:

Information Systems Control Environment:

OPM is charged with the oversight and accountability for the governance of the information technology (IT) control environment, including general IT controls, and has not taken appropriate action to address ongoing pervasive deficiencies that have been identified in multiple information systems and reported to management as a significant deficiency or material weakness since fiscal year 2007. This resulted in a material weakness.

Entity Level Controls Over Financial Management:

During FY 2015, OPM reported a data breach which affected millions of Federal employees and Government contractors. Based on KPMG's procedures to evaluate the potential impact of the data breach on OPM's financial statements, KPMG noted a number of control deficiencies that were pervasive throughout the agency. This resulted in a significant deficiency.

Material Weakness and Significant Deficiency Reported In FY 2015



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

OPM agreed to the findings and recommendations reported by KPMG.

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

KPMG noted no matters involving the internal control over the financial process for the closing package financial statements that are considered a material weakness or significant deficiency. In addition, KPMG disclosed no instances of noncompliance or other matters that are required to be reported. The objectives of KPMG's audits of the closing package financial statements did not include expressing an opinion on internal controls or compliance with laws and regulations, and KPMG, accordingly, did not express such opinions.

**FY 2015
Closing Package
Statements
Receive Another
Clean Opinion**

OPM's FY 2015 Closing Package Financial Statements

WASHINGTON, D.C.

Report No. 4A-CF-00-15-028

NOVEMBER 16, 2015

The closing package financial statements are required to be audited in accordance with GAGAS and the provisions of OMB's Bulletin No. 15-02. OPM's Closing Package Financial Statements include:

- The reclassified balance sheets, the statements of net cost, the statements of changes in net position, and the accompanying financial report notes as of September 30, 2015 and 2014;
- The Additional Note Nos. 30 and 31 (discloses other data necessary to make the Closing Package Financial Statements more informative); and,
- The Trading Partner balance sheets, the statements of net cost, and the statements of changes in net position (showing the funds due between OPM and other agencies) as of September 30, 2015.

KPMG reported that OPM's closing package financial statements are presented fairly, in all material respects.

Special Review of OPM's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group and Its Subcontractor, CSidentity

WASHINGTON, D.C.

Report No. 4K-RS-00-16-024

DECEMBER 2, 2015

In April 2015, OPM discovered that the personnel data (e.g., full name, birth date, home address, and social security number) of 4.2 million current and former Federal government employees had been stolen in a cyber-attack on OPM systems. In order to mitigate the risk of fraud and identity theft, OPM's OCIO determined that credit monitoring and identity theft services would be needed to protect the affected individuals.

On June 2, 2015, OPM's Office of Procurement Operations (OPO) signed a binding agreement with Winvale Group, LLC, who subcontracted with CSidentity, also known as CSID, and OPO issued a blanket purchase agreement call order for \$7,792,114, not to exceed \$20,760,742, for 18 months of credit report access and monitoring



and \$1 million in identity theft insurance and recovery services for each of the affected individuals.

Our special review was initiated and conducted to determine if OPO awarded the Winvale contract in compliance with the Federal Acquisition Regulations (FAR) and OPM's policies and procedures.

**Areas of
Non-Compliance
Identified in
Winvale Contract**

Our auditors identified five areas of noncompliance with the FAR and OPM's policies and procedures, as follows:

- The performance work statement for this contract did not include measurable performance standards and the method of assessing contractor performance, as required by the FAR.
- OPO inappropriately concluded that the market research performed during the contract acquisition process was sufficient and did not require further analysis by a small business specialist. They also did not submit contract Requirements to the General Services Administration (GSA), to contract through GSA's Federal Supply Schedule

as encouraged by the FAR, because an award through GSA would have caused the OCIO to not meet its self-imposed timeline for awarding the contract.

- The acquisition plan was not approved by a higher level OPO official, above the contracting officer responsible for the contract, prior to the contract award in June 2015.
- OPO issued a blanket purchase agreement call order in June 2015, for \$7,792,114, exceeding the FAR blanket purchase agreement limitation of \$6.5 million for individual purchases of a commercial item acquisition.
- Key contract documents, such as the market research plan, acquisition plan, and System for Award Management support, were not prepared until after the contract award.

OPO agreed with four and partially agreed with one of our five areas of non-compliance. While we are unable to determine if these areas of noncompliance would have resulted in the award of the contract to a party other than Winvale, it is evident that significant deficiencies existed in OPO's management of the contract award process.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Special Audits

In addition to health insurance and retirement programs, OPM administers various other benefit programs for Federal employees which include the: Federal Employees' Group Life Insurance (FEGLI) Program; Federal Flexible Spending Account (FSAFEDS) Program; Federal Long Term Care Insurance Program (FLTCIP); and, Federal Employees Dental and Vision Insurance Program (FEDVIP). Our office also conducts audits of Pharmacy Benefit Managers (PBMs) that coordinate pharmacy benefits for the FEHBP carriers. The objective of these audits is to ensure that costs charged and services provided to Federal subscribers are in accordance with the contracts and applicable Federal regulations. Additionally, our staff performs audits of the Combined Federal Campaign (CFC) to ensure that monies donated by Federal employees are properly handled and disbursed to charities according to the designations of contributing employees, and audits of Tribal enrollments into the FEHBP.

During this reporting period we issued three final audit reports and a management alert letter. Two of our audits and the management alert letter are summarized below.

Tribal Insurance Processing System as Administered by the National Finance Center for Contract Years 2012 through 2014

NEW ORLEANS, LOUISIANA

Report No. 1L-0A-00-14-074

NOVEMBER 16, 2015

In March 2010, the Affordable Care Act was signed into law, and incorporated the Indian Health Care Improvement Act. This Act entitles Indian tribes, tribal organizations, and urban Indian organizations (collectively known as Tribal Employers) to carry out programs to purchase FEHBP coverage, rights, and benefits for their employees, provided that the necessary employee deductions are made and Tribal Employer contributions are paid.

OPM has overall responsibility for administering the FEHBP, including Tribal Employer participation in the FEHBP. Beginning in FY 2012, OPM's Healthcare and

Insurance Office entered into a series of service level agreements) with the U.S. Department of Agriculture, National Finance Center to act as the paymaster for Tribal Employer participation in the FEHBP, which includes the responsibility for maintaining the enrollment system of record, and collecting insurance premium payments and operations and maintenance fees from Tribal Employers through the Tribal Insurance Processing System (TIPS). The Operations and Maintenance fees are used to reimburse the National Finance Center for its expenses in administering TIPS. The National Finance Center's responsibilities under its service level agreements with OPM are carried out at its office in New Orleans, Louisiana.

Our auditors identified the following areas requiring improvement:

- OPM and the National Finance Center's FY 2014 service level agreements to administer TIPS

did not address how to handle surplus operations and maintenance fees, which totaled \$187,063;

**Auditors Questioned
\$187,063 in Surplus
Funds that NFC Could
Put to Better Use for
the Tribal Program**

Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



- TIPS undercharged three enrollees by \$18,090 and overcharged one enrollee by \$755 in FEHBP premiums, due to system errors; and,
- The Tribal Employers for four enrollees did not correctly input the enrollees' Health Benefits Election Form data into TIPS, and the Tribal Employers for an additional three enrollees did not respond to questions regarding similar data entry errors.

The National Finance Center agreed with all of the audit findings and is in the process of working with OPM to implement corrective actions sufficient to close the audit recommendations.

Federal Employees Dental and Vision Insurance Program Operations as Administered by Aetna Dental for Contract Years 2010 through 2013

BLUE BELL, PENNSYLVANIA

Report No. 1J-0D-00-15-037

FEBRUARY 16, 2016

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 established a dental and vision benefits program for Federal employees, annuitants, and their eligible family members. The Federal Employees Dental and Vision Insurance Program (FEDVIP) carriers sign contracts with OPM to provide dental and vision insurance services for a term of seven years.

OPM awarded a contract to Aetna Life Insurance Company (Plan) to administer dental benefits under the FEDVIP. The primary objective of this audit was to determine whether costs charged to the FEDVIP and services provided to members were in accordance

**Aetna Proposed
Premium Rates
Using Inaccurate
and Unsupported
Pricing Information**

with the terms of the contract between OPM and the Plan. Our audit included a review of the Plan's annual accounting statements, internal policies and procedures, fraud and abuse program, claims processing, and premium rates for contract years 2010 through 2013.

Our audit identified two areas requiring improvement. Specifically, the Plan:

- Did not properly coordinate the payment of benefits for 4 out of 102 claims that we reviewed from contract year 2013; and,
- Misreported numerous pricing assumptions in its 2010 through 2013 premium rate proposals.

The Plan agreed with all of the audit findings and is in the process of working with OPM to implement corrective actions sufficient to close the audit recommendations.

Management Alert – Serious Concerns Related to OPM's Procurement Process for Benefit Programs

WASHINGTON, D.C.

Report No. 4A-RI-00-16-014

OCTOBER 14, 2015

The OIG issued a Management Alert memorandum to the Acting Director of OPM detailing our concern with the agency granting contract extensions to Automatic Data Processing (ADP), the sole source contract holder administering the Federal Flexible Spending Account Program, and Long Term Care Partners, the sole source contract holder administering the Federal Long Term Care Insurance Program (FLTCIP).

The multiple contract extensions granted by OPM's Federal Employee Insurance Operations group (FEIO) exceeded ADP's original contract term by seven years and Long Term Care Partners' second contract by one year, thereby eliminating competition that would help control costs associated with these programs.



Audit Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

OPM's management disregarded several notices from both the OIG and OPM's own Center for Internal Controls and Risk Management office that showed the risk associated with these contract extensions, and FEIO's conflict of interest related to ensuring program continuity versus acquiring the services at the best value considering the price under competition.

We recommended that OPM:

- Stop granting contract extensions and immediately rebid the Flexible Spending Account and the Federal Long Term Care Insurance Program contracts;
- Implement controls to ensure that the program procurements and contract periods adhered to Federal regulations;

- Consider consolidating all contract administration functions under OPM's OPO; and,
- Ensure that future contracting officers do not have a dual responsibility to administer the program operations.

Since the issuance of our management alert letter in October 2015, both the Flexible Spending Account and Federal Long Term Care Insurance Program contracts have been successfully rebid and awarded. Furthermore, the OPO and FEIO have conducted status update meetings with the OIG on a bi-weekly basis since November 2015.



Enforcement Activities

Investigative Cases

The Office of Personnel Management administers benefits from its trust funds, with approximately \$1 trillion in assets for all Federal civilian employees and annuitants participating in the Civil Service Retirement System, the Federal Employees Retirement System, FEHBP, and FEGLI. These programs cover over nine million current and retired Federal civilian employees, including eligible family members, and disburse over \$135 billion annually. The majority of our OIG criminal investigative efforts are spent examining potential fraud against these trust funds. However, we also investigate OPM employee and contractor misconduct and other wrongdoing, such as fraud within the personnel security and suitability program administered by OPM.

During the reporting period, our criminal investigations led to 13 arrests, 24 indictments and informations, 20 convictions and \$8,202,207 in monetary recoveries to OPM-administered trust funds. Our criminal investigations, many of whom worked jointly with other Federal law enforcement agencies, also resulted in \$4,014 in criminal fines and penalties, which are returned to the General Fund of the Treasury, asset forfeitures, and court fees and/or assessments. For a statistical summary of our office's investigative activity, refer to the table on page 39.

HEALTH CARE FRAUD CASES

Health care fraud cases are often time-consuming and complex, and may involve several health care providers who are defrauding multiple health insurance plans. Our criminal and civil investigations are critical to protecting Federal employees, annuitants, and members of their families who are eligible to

participate in the FEHBP. Of particular concern are cases that involve harm to the patients, pharmaceutical fraud, and the growth of medical identity theft and organized crime in health care fraud, all of which have affected the FEHBP.

We remain very concerned about the FEHBP's exclusion from the Anti-Kickback Act and have proposed legislation to correct that omission. As the many of the cases described in this report reflect, the FEHBP is frequently victimized by the payment of kickbacks.

We coordinate our health care fraud investigations with the Department of Justice (DOJ) and other Federal, state, and local law enforcement agencies. We are participating members of health care fraud task forces across the nation. We work directly with U.S. Attorney's Offices nationwide to focus investigative resources in areas where fraud is most prevalent.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Our special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and enrollees. Additionally, special agents work closely with our auditors when fraud issues arise during carrier audits. They also coordinate with the OIG's debarring official when investigations of FEHBP health care providers reveal evidence of violations that may warrant administrative sanctions. The following investigative cases represent some of our activity during the reporting period.

HEALTH CARE FRAUD CASES

Pharmaceutical Company Agrees to Pay \$125 Million to Resolve Illegal Prescription Drug Marketing Allegations

In October 2015, Warner Chilcott U.S. Sales LLC, a subsidiary of pharmaceutical manufacturer Warner Chilcott PLC, pled guilty to a felony charge of health care fraud. The plea agreement is part of a global settlement with the United States in which Warner Chilcott has agreed to pay \$125 million to resolve its criminal and civil liability arising from the company's illegal marketing of the drugs Actonel®, Asacol®, Atelvia®, Doryx®, Enablex®, Estrace® and Loestrin®. Prior to October's guilty plea by Warner Chilcott, several individuals also pled guilty or were charged in connection with the company's illegal activities.

Investigation revealed that the company paid kick-backs to physicians throughout the United States to induce them to prescribe its drugs, manipulated prior authorizations to induce insurance companies to pay for prescriptions of Atelvia® that the insurers may not have otherwise paid for, and made unsubstantiated marketing claims for the drug Actonel®.

In a criminal information filed in the District of Massachusetts, the Government charged that, between 2009 and 2013, Warner Chilcott, through employees acting at the direction of members of the company's management team, knowingly and willfully paid remuneration to physicians in order to

induce those physicians to prescribe Warner Chilcott drugs. Specifically, the information alleges that Warner Chilcott provided payments, meals and other remuneration associated with so-called "Medical Education Events," which included dinners, lunches and receptions. These events, which were often held at expensive restaurants, often contained minimal or no educational component and were instead used to pay prescribing physicians in an attempt to gain a competitive advantage over other companies. Warner Chilcott also enlisted high-prescribing physicians as "speakers" for the company. In fact, the "speakers" often did not actually speak about any clinical or scientific topics, and, instead, the payments were primarily intended to induce prescriptions. For instance, Warner Chilcott informed "speakers" who were not prescribing at a high volume that they would not be paid for subsequent events unless their prescribing habits increased.

In addition, the information alleges that from 2011 to 2013, Warner Chilcott employees knowingly and willfully submitted false, inaccurate, or misleading prior authorization requests and other coverage requests to Federal health care programs for the osteoporosis medications Atelvia® and Actonel®. The false, inaccurate and misleading information was provided to certain insurance companies in order to overcome formulary restrictions that favored less expensive osteoporosis drugs. For instance, Warner Chilcott was aware that many insurers only paid for Atelvia® if a physician submitted an individualized request explaining why the patient could not be treated with less-expensive medications approved to treat the same conditions.

As detailed in the information, Warner Chilcott sales representatives filled out numerous prior authorizations for Atelvia®, using "canned" medical justifications which often were inconsistent with the patients' medical conditions. In some instances, according to the information, Warner Chilcott sales representatives submitted these prior authorizations directly to insurance companies, holding themselves out to be physicians. In other

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



cases, sales representatives coached physicians and staff about which medical justifications would result in an approved prior authorization, whether or not the justification was true for a particular patient.

Finally, the information alleges that Warner Chilcott employees were instructed by members of the company's management team to make unsubstantiated superiority claims when marketing the drug Actonel®. The management team instructed the sales representatives to tell physicians that Actonel® was superior to other bisphosphonates due to its supposedly unique "mechanism of action." Warner Chilcott managers also encouraged sales representatives to use props to visually support this false claim, including pouring water and syrup onto two sponges while telling physicians that Actonel, like water, penetrated and exited the bone more quickly than its competitors, represented by the syrup. Warner Chilcott management directed the sales representatives to make the superiority claim even though the claim was not supported by clinical evidence.

Under the terms of the plea agreement, Warner Chilcott will pay a criminal fine of \$22.94 million. Warner Chilcott also entered into a civil settlement agreement under which it agreed to pay \$102.06 million to the Federal Government and the States to resolve claims arising from its conduct, which allegedly caused false claims to be submitted to Government health care programs. The Federal share of the civil settlement is approximately \$91.5 million, and the State Medicaid share of the civil settlement is approximately \$10.6 million. As a result of this civil settlement, the FEHBP is expected to recover \$1,073,605 in damages.

This case was worked jointly by the Federal Bureau of Investigation (FBI), U. S. Department of Health and Human Services (HHS) OIG, Department of Defense's Defense Criminal Investigative Service (DCIS), Food and Drug Administration's (FDA) Office of Criminal Investigations, Department of Veterans Affairs (VA), and OPM OIG.

Millennium Health Agrees to Pay \$256 Million to Resolve Medically Unnecessary Drug and Genetic Testing Allegations

In October 2015, Millennium Health, formerly Millennium Laboratories, agreed to pay \$256 million to resolve allegations that it billed Medicare, Medicaid, and other Federal health care programs for medically unnecessary drug testing and genetic testing, and provided kickbacks to physicians to induce business. Millennium, headquartered in San Diego, California, is one of the largest urine drug testing laboratories in the United States.

Millennium agreed to pay \$227 million to resolve False Claims Act allegations that it systematically billed Federal health care programs for excessive and unnecessary drug testing from January 2008 through May 2015. The United States alleged that Millennium caused physicians to order excessive numbers of urine drug tests, in part through the promotion of "custom profiles," which, instead of being customized for individual patients, were in effect standing orders that caused physicians to order large numbers of tests without an individualized assessment of each patient's needs. Millennium's use of the so-called "custom profile" led to the over-billing of Federal health care programs, which limit payment to services that are reasonable and medically necessary for the treatment and diagnosis of an individual patient's illness or injury. The United States also alleged that Millennium provided physicians with free drug test cups on the express condition that the physicians return the specimens to Millennium for hundreds of dollars' worth of additional testing. Millennium also agreed to pay \$10 million to resolve allegations that it submitted false claims to Federal health care programs for medically unnecessary genetic testing that was performed on a routine and preemptive basis, without an individualized assessment of need, from January 2012 through May 2015. Routine genetic testing is not medically reasonable and necessary, and therefore does not qualify for Medicare reimbursement.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

As a result of the settlement, the FEHBP received \$4,807,992.

The investigation was conducted by the: FBI; HHS OIG; Centers for Medicare & Medicaid Services (CMS); VA OIG; United States Postal Inspection Service (USPIS); and, the OPM OIG.

Kroger Agrees to a \$21.5 Million Settlement for Employing Excluded Pharmacists

In July 2015, the OPM OIG received notification from the HHS OIG that through internal checks and balances, the Kroger Company discovered that they employed pharmacists in their pharmacies that were banned or excluded by the HHS OIG and they self-disclosed these findings to the HHS OIG.

In November 2015, Kroger signed a civil settlement agreement, in which they agreed to pay \$21,523,047 in restitution and penalties. It was alleged that from July 2001 through October 2014, Kroger employed and utilized pharmacists in their pharmacies that had been excluded by the HHS OIG.

The FEHBP received \$628,710 in restitution and \$314,355 in penalties, for a net recovery award of \$943,065.

Two Florida Pharmacies Agree to Over \$5 Million Settlement for Tainted Prescriptions

Our investigation into Topical Specialist Pharmacy (Topical) began when the Jacksonville United States Attorney's Office (USAO) issued a Civil Investigative Demand (CID) to Well Health, another Jacksonville pharmacy our office was also investigating. After issuance of the CID, Well Health made a self-disclosure to the Government. The disclosure revealed that a vast majority of Well Health's prescriptions were potentially tainted by kickbacks – and all prescriptions written through Topical were tainted.

In late 2012, the owner of Well Health was approached by a personal friend who was interested in compounded prescriptions. The friend, a cardiologist, was interested in prescribing these medications and interested in the high rate of reimbursement associated with compounded prescriptions. The cardiologist proposed that he and other physicians could submit prescriptions for compounded substances if the treating physicians enrolled their patients in a "research study." The research study was purportedly to understand the efficacy of compounded prescriptions. In order for the treating physicians to actually receive a percentage of the prescription reimbursement, the treating physicians agreed to call themselves research study consultants and they received reimbursements in excess of \$400 an hour for their time.

In an effort to preserve an aura of legitimacy, the cardiologist and the owner of Well Health agreed to create a new company, Topical, to handle the "research study". Under their plan, Topical was envisioned to be the conduit to submit claims for compounded prescriptions to Federally subsidized health care programs.

Topical was registered with the State of Florida in February 2013. There were five members: the owner of Well Health, the cardiologist, and three other physicians in the Jacksonville area. While Topical received corporate status, it lacked the relevant licensure to submit claims for prescriptions to the Federal health care programs. Undeterred, and not wanting to miss out on the lucrative compounded prescription market, Topical's principals decided that the prescriptions would be submitted in Well Health's name until Topical received the appropriate licenses. Topical never received the appropriate licenses. Accordingly, all prescriptions were submitted via Well Health. The four Topical physicians eventually wrote over 780 prescriptions for compounded substances in two years.

In November 2015, settlement agreements were signed between the Federal Government and Topical

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



and Well Health. Well Health agreed to repay the Federal Government more than \$3 million as well as 50 percent of its net profits for five years. As a result of the Well Health Settlement, the FEHBP will receive \$195,452. As a result of the Topical settlement, they agreed to repay the Federal Government \$2.24 million with the FEHBP receiving \$115,957.

This case was worked jointly by DCIS, VA OIG, HHS OIG, FBI, and, OPM OIG.

Postal Employee Found Guilty of Worker's Compensation Fraud

In October 2008, the United States Postal Service (USPS) OIG contacted our office regarding a Postal employee they were investigating who was fraudulently receiving workers' compensation benefits. The USPS OIG believed that the employee was not entitled to the benefits since she was capable of working even though she led them to believe that she wasn't able to perform her work duties. Additionally, she applied for OPM disability retirement benefits. The employee never revealed to OPM that she was receiving workers' compensation benefits which made her ineligible to receive OPM disability retirement benefits at the same time.

In September 2009, the USPS OIG initiated surveillance on the employee. She was observed on multiple occasions exceeding her medical restrictions. The investigation also disclosed that she was actively involved in riding and showing horses. The USPS OIG undercover agent contacted the employee about riding together. Over the next two months, the undercover agent and the Postal agent went horseback riding together on several occasions.

In October 2013, the employee was charged in an eleven count Federal indictment which included mail fraud, false or fraudulent statements, and conversion of Government Funds. A few days later, she was arrested.

In August 2015, the employee was found guilty on ten of the eleven counts after a nine day jury trial. The jury found that she unlawfully received OPM disability retirement benefits and Federal workers' compensation benefits.

In November 2015, the employee was sentenced to serve 36 months in jail and 3 years' probation. Additionally, she was ordered to pay \$194,486 in restitution, with \$164,428 to the U.S. Department of Labor (DOL) and \$30,058 to OPM.

This case was worked jointly by DOL OIG, USPS OIG, and our office.

Acupuncturist Found Guilty of Insurance Fraud

Our investigation involved a licensed acupuncturist who was advised and educated by BlueCross BlueShield of Texas (BCBSTX) on prior occasions that billing for evaluation and management services was outside his scope of practice. Despite that education, the acupuncturist continued to bill BCBSTX for evaluation and management services. The investigation determined that the acupuncturist would begin billing for the evaluation and management services once the member's maximum annual benefits for acupuncture had been met, as a way to be compensated for the acupuncture he performed.

In March 2015, the acupuncturist was indicted on a charge of insurance fraud in Wichita County, Texas. A plea deal was reached where he agreed to repay \$100,000 to the FEHBP before he officially entered his plea. OPM received a check for \$100,000 in October 2015.

In November 2015, the acupuncturist officially entered his plea and was convicted of insurance fraud, greater than \$20,000 but less than \$100,000, a third degree felony in Wichita County, Texas. The acupuncturist was sentenced to two years deferred



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

adjudication community supervision and was ordered to pay the remaining \$37,893 in restitution.

The investigation was worked in cooperation with the Texas Department of Insurance.

Speech Therapists Found Guilty of Conspiracy and Health Care Fraud

This investigation was initiated in January 2014 at the request of the DCIS. At the time of referral to the OPM OIG, the case was already under indictment and was in trial preparation. The investigation focused on allegations that two speech therapists were billing for services that were not medically necessary and/or not rendered. Many of the services billed involved treatment for dysphagia, a swallowing and oral feeding dysfunction. However, neither therapist had the equipment to perform those treatments.

One of the two defendants was also the owner of the clinic that employed the other defendant and several other therapists who were not part of the investigation. That owner also admitted that she submitted \$925,140 in false and fraudulent claims for herself, her co-defendant and three unsuspecting employees for various medical and speech therapy services that were not provided, including \$110,550 in false and fraudulent claims under the medical insurance of one unsuspecting employee.

In total, TRICARE and BlueCross BlueShield of Texas received approximately \$3,784,642 in false and fraudulent claims from the defendants and paid approximately \$1,285,827 on those claims.

In August 2014, the co-defendant pled guilty to conspiracy and health care fraud. In March 2015, the co-defendant and owner pled guilty to conspiracy and health care fraud.

In October 2015, both were sentenced. The owner defendant was sentenced to 151 months incarceration and 36 months of supervised release. She was ordered to pay a \$600 fee and \$1,297,645 in restitution. The employee co-defendant was sentenced to 51 months incarceration and 36 months of supervised release. She was ordered to pay a \$500 fee and \$1,297,645 in restitution. The restitution amount was ordered severally and jointly.

The FEHBP will receive \$15,556 in restitution.

The case was investigated jointly with the DCIS.

World Traveling Duo Sentenced for Health Care Fraud

For nearly six years, a retired State Department employee and his partner traveled throughout Europe and elsewhere funded by the submission of fraudulent health care claims to the Foreign Service Benefit Plan administered by Aetna, an FEHBP contracted health insurance carrier.

From January 2007 through January 2013, the duo submitted nearly \$600,000 in fraudulent prescription claims purportedly from overseas pharmacies and \$637,000 in medical care services purportedly received from overseas health professionals. The duo conspired to present these claims for reimbursement to their health insurer alleging that those services were rendered. Our investigation found that the couple was paid \$257,000 for medical supplies and services that were, in fact, never rendered and nearly \$800,000 more in questionable payments that were believed fictitious.

In July 2015, the two were arrested by special agents and in October 2015, they both independently pled guilty to health care fraud.

In March 2016, they were each sentenced to 15 months incarceration and ordered to pay \$257,000 in restitution to the FEHBP. This case was investigated by the FBI, the USPIS, and our office.

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



Virginia Hospital and Oncologist Agree to Settlement for False Claims Accusations

A Virginia hospital and oncologist agreed to settle false claims allegations that they knowingly made, used, or caused to be made false records or statements material to the submission of false health insurance claims related to breast cancer screenings. The United States contended that the submission of claims by the hospital were not medically necessary and/or were not payable claiming that the doctor falsified documents with incorrect diagnosis codes to indicate a diagnosis, such as 'lump or mass in breast' for medically unnecessary and/or non-covered breast screening examinations and studies for the early detection of breast cancer.

The United States further alleged that the breast examinations in connection with annual screening mammograms were not covered by payers before January 1, 2011, and that the doctor arranged for certain patients to receive breast screening examinations and breast screening ultrasound studies. These examinations and screenings were determined to be improperly coded by the doctor as "diagnostic" ultrasounds and examinations, with a falsified diagnosis code, which resulted in payments from Federal health insurance carriers for non-covered screening examinations and studies.

As part of the settlement agreement, the hospital and the doctor did not admit guilt or agree with the Government's allegations, but rather they agreed to settle the allegations with financial restitution to Federal health insurance carriers in the amount of \$400,000. As part of the settlement agreement, OPM will receive \$24,250.

RETIREMENT FRAUD

Under the law, entitlement to annuity payments ceases upon the death of an annuitant or survivor annuitant (spouse). The most common type of retirement fraud involves the intentional receipt and use of Civil Service Retirement System (CSRS) or Federal Employees Retirement System (FERS) annuity benefit payments by an unentitled recipient. However, retirement fraud can also include incidents of elder abuse.

Our Office of Investigations uses a variety of approaches to identify potential retirement fraud cases for investigation. We coordinate closely with OPM's Retirement Services office to identify and address program vulnerabilities. We also coordinate with the Department of the Treasury's Financial Management Service to obtain payment information. Other referrals come from Federal, state, and local agencies, as well as private citizens. The OIG also works proactively to identify retirement fraud.

The following retirement fraud investigations represent some of our activities during the reporting period.

RETIREMENT FRAUD CASES

Maryland Woman Guilty of Defrauding Mother's Civil Service Retirement Benefits

The daughter of a Federal annuitant pled guilty in March 2016 to the theft of over \$700,000 in Civil Service Retirement System funds paid to her deceased mother. The mother was receiving retirement benefits following retirement from her civil service career, as well as receiving survivor benefits from the death of her husband following his retirement from Federal service. Though the daughter reported the deaths to the State of Maryland in October 2002, she also contacted OPM and falsely reported that her mother was still alive.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Consequently, OPM continued to issue monthly retirement and survivor annuity benefit payments to her mother through March 2010, totaling \$702,950.

To perpetuate the fraud over the years, the daughter sent at least three vital status letters to OPM which all falsely bore the signature of her deceased mother. In fact, one such letter was notarized. Further investigative efforts revealed that other official Government documents were submitted in an effort to conceal the fraud.

In February 2016, a criminal information was filed with the District of Columbia charging the daughter with first degree fraud, theft, and bank fraud, and in March 2016, the daughter pled guilty to theft. She will be sentenced later this year.

Granddaughter Steals Deceased Annuitant's Benefit Payments

We initiated this investigation after receiving an allegation that a Federal survivor annuitant died in 2001 and her granddaughter continued to receive her annuity benefit payments for over 11 years.

Our investigation confirmed that the annuitant's granddaughter maintained a joint bank account with the annuitant where the annuity benefit payments were electronically deposited. The annuitant died in June 2001 and OPM was not notified of her death. OPM continued to issue annuity payments via electronic funds transfer to the bank account jointly held by the annuitant and her granddaughter, resulting in an overpayment of \$110,328.

Special agents interviewed the granddaughter who admitted that she converted the retirement annuity payments to her own personal use after her grandmother's death. She also stated that she thought she was entitled to the money.

In October 2015, the granddaughter signed a civil settlement agreement to pay OPM the full annuity overpayment amount of \$110,328 plus interest.

Son Steals Deceased Mother's Social Security and OPM Annuity Benefits

In May 2014, OPM OIG was contacted by the Social Security Administration (SSA) OIG, who related that they were investigating an individual who was fraudulently receiving social security benefits and, during the course of their investigation, the SSA OIG discovered that the same individual was also fraudulently receiving retirement benefits from OPM.

We determined that OPM was never notified of the Federal annuitant's death in 2007 and, as a result, the annuitant's son received \$83,279 in annuity payments to which he was not entitled. For over seven years, the son collected his mother's annuity benefits which were sent via electronic funds transfer to a joint bank account in the names of the annuitant and her son.

In May 2015, the son was indicted in Indiana and subsequently arrested. In September 2015, he pled guilty to defrauding both the SSA and OPM.

In November 2015, the son was sentenced to 36 months of probation, and ordered to pay restitution in the amount of \$221,947. He was ordered to pay \$138,667 to SSA and \$83,279 to OPM.

This case was worked jointly by the SSA OIG and our office.

REVOLVING FUND PROGRAM INVESTIGATIONS

Our office investigates OPM employee and contractor misconduct and other wrongdoing, including allegations of fraud within OPM's Revolving Fund programs, such as the background investigations program and human resources products and services.

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



OPM's Federal Investigative Services (FIS) conducts background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducts 95 percent of all personnel background investigations for the Federal Government. With a staff of over 8,200 Federal and contract employees, FIS processed over 2.4 million background investigations in FY 2015. Federal agencies use the reports of investigations conducted by OPM to determine individuals' suitability for employment and eligibility for access to national security classified information.

The violations investigated by our criminal investigators include contract violations, as well as fabrications by OPM background investigators (i.e., the submission of work products that purport to represent investigative work which was not in fact performed). We consider such cases to be a serious national security and public trust concern. If a background investigation contains incorrect, incomplete, or fraudulent information, a qualified candidate may be wrongfully denied employment or an unsuitable person may be cleared and allowed access to Federal facilities or classified information.

OPM's Human Resources Solutions (HRS) provides other Federal agencies, on a reimbursable basis, with human resource products and services to help agencies develop leaders, attract and build a high quality workforce, and transform into high performing organizations. For example, HRS operates the Federal Executive Institute, a residential training facility dedicated to developing career leaders for the Federal Government. Cases related to HRS investigated by our criminal investigators include employee misconduct, regulatory violations, and contract irregularities.

The following Revolving Fund investigations represent some of our activities during the reporting period.

Former OPM Contract Background Investigator Convicted of Falsifying Numerous Background Investigations

In May 2013, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by a former OPM contract background investigator employed by United States Investigations Services (USIS).

From July 2010 to March 2011, in more than two dozen Reports of Investigations, the background investigator indicated that he had conducted an interview or reviewed a record regarding the subject of the background investigation, when in fact he had not. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

The former USIS contract background investigator pled guilty, in the U.S. District Court for the District of Columbia, to making a false statement and was sentenced in February 2016 to serve 36 months of supervised probation, conduct 300 hours of community service, and ordered to pay restitution of \$91,124 to OPM.

Former OPM Contract Background Investigator Falsifies Approximately 50 Background Investigations

In October 2011, our office received an allegation from the FIS Integrity Assurance Group regarding misconduct and false statements made by a former OPM contract background investigator employed by KeyPoint.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

From October 2010 and July 2011, in approximately 50 Reports of Investigations, the background investigator indicated that he had conducted an interview or reviewed a record regarding the subject of the background investigation, when in fact, he had not. These reports were utilized and relied upon by Federal agencies requesting the background investigations to determine whether these subjects were suitable for positions having access to classified information, for positions impacting national security and public trust, or for receiving or retaining security clearances. These false representations required FIS to reopen and reinvestigate numerous background investigations assigned to the background investigator.

A criminal information for making a false statement was filed against the former contract background investigator and he pled guilty in February 2016, in the District of Columbia. The charge carries a statutory penalty of up to five years in prison and a fine of up to \$250,000. As part of the plea, the former KeyPoint contract background investigator has agreed to pay \$85,779 in restitution to OPM. Sentencing is scheduled for May 2016.

Former OPM Contract Record Courier Uses False Credentials to Obtain Court Records

In July 2015, our office received an allegation from the FIS Integrity Assurance Group regarding the use of false credentials by a former OPM contract record courier. The Hillsborough County Sheriff's Office in Tampa, Florida informed OPM that the former USIS contract record courier presented himself as an OPM contract background investigator with expired and altered OPM FIS credentials to various court clerks in order to obtain unredacted records free of charge.

In September 2015, the fraudulent credentials were recovered by an OIG agent and the former USIS contract courier was interviewed. The former contract

courier admitted after his employment ended with USIS, for approximately ten years, he falsely identified himself on numerous occasions as an OPM contract investigator to various court clerks, in Florida's Hillsboro and Pinellas Counties, by using altered and expired credentials in order to obtain unredacted court records free of charge.

The former USIS contract record courier pled guilty, in the U.S. District Court for the Middle District of Florida, to using false credentials and was sentenced in January 2016 to pay a \$1,000 fine.

OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number, email address, and mailing address are listed on our OIG Web site at www.opm.gov/oig, along with an online anonymous complaint form. Contact information for the Hotline is also published in the brochures for all of the FEHBP health insurance plans. Those who report information to our Hotline can do so openly, anonymously, and confidentially without fear of reprisal.

The information we receive on our OIG Hotline generally concerns customer service issues, FEHBP health care fraud, retirement fraud, and other complaints that may warrant investigation. Our office receives inquiries from the general public, OPM employees, contractors, and others interested in reporting waste, fraud, and abuse within OPM and the programs it administers.

We received 1,182 hotline inquiries during the reporting period, with 231 pertaining to health care and insurance issues, and 951 concerning retirement or special investigation. The table on page 49 reports the summary of hotline activities including telephone calls, emails, and letters.

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



OIG and External Initiated Complaints

Based on our knowledge of OPM program vulnerabilities, information shared by OPM program offices and contractors, and our liaison with other law enforcement agencies, we initiate our own inquiries into possible cases involving fraud, abuse, integrity issues, and occasionally malfeasance.

During this reporting period, we initiated 64 preliminary inquiry complaints related to retirement fraud and special investigations. We also initiated 1,817 health care fraud preliminary inquiry complaints. These efforts may potentially evolve into formal investigations.

We believe that these OIG and external initiated complaints complement our hotline to ensure that our office continues to be effective in its role to guard against and identify instances of fraud, waste, and abuse.

Debarment Initiative Update

Effective March 2013, OPM implemented a new suspension and debarment program, which is separate from OIG's administrative sanctions of FEHBP health care providers. The program covers the debarment of OPM contractors and employees who have violated the terms of their contract or employment. During this reporting period, the OIG referred 20 cases to the agency for debarment action, for a total of 90 referrals since the inception of the program. OPM issued debarment letters to 8 individuals between October 1, 2015 and March 31, 2016. The majority of cases we have referred for debarment action were former FIS employees and contractors. Most of these former FIS employees and contractors are referred to us through FIS' Integrity Assurance Group. Although these individuals were removed from Government employment or from the relevant OPM contract, we feel that Government-wide contract debarment action for these individuals is necessary to protect the integrity of Federal programs.

Our office will continue to develop and refer cases where we believe a Government-wide debarment is necessary in order to protect the integrity of OPM, as well as other Federal agencies and programs.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Administrative Sanctions of FEHBP Health Care Providers

Under the FEHBP administrative sanctions statute, we issue debarments and suspensions of health care providers whose actions demonstrate that they are not responsible to participate in the program. At the end of the reporting period, there were 33,924 active suspensions and debarments from the FEHBP.

During the reporting period, our office issued 376 administrative sanctions – including both suspensions and debarments – of health care providers who have committed violations that impact the FEHBP and its enrollees. In addition, we responded to 2,342 sanctions-related inquiries.

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

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

Sanctions serve a protective function for the FEHBP and the Federal employees who obtain, through it, their health insurance coverage. The following articles, highlighting a few of the administrative sanctions handled by our office during the reporting period, illustrate their value against health care providers who have placed the safety of enrollees at risk, or have obtained fraudulent payment of FEHBP funds.

Debarment disqualifies a health care provider from receiving payment of FEHBP funds for a stated period of time. The FEHBP administrative sanctions program establishes 18 bases for debarment. The ones we cite most frequently are for criminal convictions or professional licensure restrictions or revocations. Before debarring a provider, our office gives prior notice and the opportunity to contest the sanction in an administrative proceeding.

Suspension has the same effect as a debarment, but becomes effective upon issuance, without prior notice or process. FEHBP sanctions law authorizes suspension only in cases where adequate evidence indicates that a provider represents an immediate risk to the health and safety of FEHBP enrollees.

Kansas Physician Debarred After Medical License is Revoked

Our office debarred a Kansas physician in March 2016 after the Kansas State Board of Healing Arts (Medical Board) revoked the physician's medical license based on his criminal conviction involving controlled substance violations. Our Office of Investigations referred this case to the OIG's Administrative Sanctions staff.

Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



The physician was indicted in 2013 by the U.S. District Court, District of Kansas. The physician operated his own clinic and carried a valid Drug Enforcement Administration (DEA) registration number authorizing him to sign and issue prescriptions for controlled substances. The indictment alleged that the physician pre-signed blank prescription forms and allowed his un-licensed staff, who were not legally authorized to prescribe controlled substances, to issue prescriptions using his name and DEA registration number. From 2007 through 2012, the physician's staff illegally issued prescriptions for controlled substances to 540 of his patients while he travelled abroad.

In 2014, the physician pled guilty to conspiracy to distribute narcotics in the U.S. District Court, District of Kansas. The doctor was sentenced to 60 months in prison; followed by three years supervised probation. In addition, he was ordered to pay \$101,000 in restitution to several insurance companies and Federal health programs.

In 2013, due to the nature of the alleged facts surrounding the criminal investigations and indictment, the Medical Board immediately suspended the physician's medical license to protect the health and safety of the public. In 2014, the Medical Board revoked the physician's medical license after he was convicted and sentenced for conspiracy to distribute narcotics.

Our debarment of the physician is for an indefinite period pending resolution of his Kansas medical licensure.

Georgia Nurse Practitioner Debarred After Loss of License Due to Health Care Insurance Fraud

We debarred a nurse practitioner in January 2016 based on the indefinite suspension of her license by the Georgia Board of Nursing. The Board of Nursing

initiated an investigation after learning of the nurse's February 2015 indictment in the Northern District of Georgia for health care fraud and aggravated identity theft.

In May 2015, the Nursing Board suspended the nurse practitioner indefinitely based on the results of their investigation and her conviction for health care fraud and identity theft. She devised a scheme to defraud Government insurance programs and private health insurance carriers for services that were never rendered. According to the U. S. Attorney's Office, Atlanta Division, during 2013 and 2014, the practitioner electronically submitted claims to health care benefit programs seeking reimbursement for \$2.2 million in fraudulent claims, of which she received more than \$1,000,000.

While working part-time at a general medical practice as an independent contract nurse, she started a health and wellness clinic that advertised services such as weight loss, hormone therapy, and allergy testing. In May 2013, she began using the personal identifying information of her patients and their families to submit fraudulent claims through the limited liability company that she owned and operated. Claims for reimbursements were submitted for patients that were never seen, and on dates that the beneficiaries did not visit the clinic.

In October 2015, the nurse practitioner pled guilty and was convicted of health care fraud and aggravated identity theft. In December 2015, she was sentenced to five years, one month in prison to be followed by three years of supervised release. In addition she was ordered to pay \$1,153,384 in restitution to health insurance companies and Federal health programs.

We debarred the nurse practitioner for an indefinite period pending resolution of her licensure by the Georgia Nursing Board.



Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

Florida Physician Debarred for Writing Fraudulent Prescriptions

In January 2016, we debarred a Florida physician specializing in osteopathic pain management after her medical license was restricted by the State of Florida Department of Health. The physician's license was restricted after she was arrested and charged with two counts of obtaining or attempting to obtain controlled substances by fraud.

The County Sheriff's Office initiated an investigation in 2015 after receiving tips that the physician was writing prescriptions for oxycodone using her patients' names to obtain the drug for her personal use. The physician was caught on surveillance video at several pharmacies purchasing drugs with the fraudulent prescriptions that she had written. Subsequently, the physician billed the patients' insurance companies for the drugs she obtained. Employees interviewed at the physician's medical facility, reported that at times, she appeared to be

impaired; exhibiting slurred speech and inability to focus. In addition, employees witnessed the physician write prescriptions for patients knowing that the patient would return the medication which she then kept for her use.

In March 2015, the Florida Department of Health issued an Order of Emergency Restriction of License (Order) because the physician's actions violated several Florida Statutes and posed a serious danger to the health, safety and welfare of the public. The Order immediately prohibited the physician from prescribing or dispensing controlled substances or practicing osteopathic medicine in any location where she has access to controlled substances.

Our administrative records identified a nexus between the provider and at least one of our FEHPB insurance carriers. Our debarment of the physician is for an indefinite period pending resolution of her Florida medical licensure.



Evaluations and Inspections Activities

The Office of Evaluations and Inspections (OEI) provides an alternative method for conducting independent, credible, and thorough reviews of OPM's programs and operations to prevent waste, fraud, and abuse. OEI quickly analyzes OPM concerns or issues that need immediate attention by using a variety of review methods and evaluation techniques. OEI reports provide OPM management with findings and recommendations that will assist in enhancing program operations, efficiency, effectiveness, and compliance with applicable policies and procedures.

OPM's Non-Career Officials' Involvement in the Freedom of Information Act Response Process

WASHINGTON, D.C.

Report Number 4K-RS-00-15-059

NOVEMBER 17, 2015

Since 1967, the Freedom of Information Act (FOIA) has provided the public the right to request access to records from any Federal agency. Agencies, including OPM, are required to release any documents requested under FOIA, unless they are considered to be one of nine statutory exemptions which protect the interests such as personal privacy, financial institutions, national security, and law enforcement and would be harmful to the Government or private interest.

OPM's FOIA Office, located within OPM's Office of the Chief Information Officer, is responsible for providing oversight in the processing of FOIA requests. The FOIA Office serves as the center for the intake and dissemination of FOIA requests to the appropriate OPM program offices, and ensures that program offices comply with FOIA guidelines, policies, and procedures.

We conducted this evaluation in response to a Congressional request from the U.S. Senate Committee on Homeland Security and Governmental Affairs (Committee), dated June 23, 2015, to determine whether non-career officials are involved in the response process of FOIA requests at OPM. Specifically, the Committee asked us to determine if involvement of non-career officials resulted in:

- Any undue delays in responding to FOIA requests; or,
- The withholding of any document or portion of any document that would have otherwise been released but for the non-career official's involvement in the process.

Our evaluation determined that OPM non-career officials were not involved in the FOIA Office's response process between January 1, 2010 and August 16, 2015.

Consequently, non-career officials' involvement did

**Non-Career
Officials Not
Involved In
the Response
Process of
FOIA Requests**



Evaluations and Inspections Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

not result in any undue delays or the withholding of any documents or portion of any documents that would have otherwise been released.

OPM's Oversight of the Federal Workers' Compensation Program

WASHINGTON, D.C.

Report Number 4K-RS-00-15-050

MARCH 29, 2016

The Federal Employees' Compensation Act (FECA) is a workers' compensation program that provides Federal employees' medical benefits, income subsidies, and certain support services in the event of a work-related injury or illness, as well as benefits to surviving family members in the event of a work-related death. The U.S. Department of Labor's (DOL) Office of Workers' Compensation Programs (OWCP) administers the FECA program. However, the cost associated with the benefits is ultimately paid by the claimant's employing agency. Each Federal agency, to include OPM, is responsible for oversight of its Workers' Compensation Program.

We conducted this evaluation to determine if OPM's Employee Services has adequate oversight of its FECA program.

Our evaluation determined that, per DOL's FECA guidelines, Employee Services needs to improve the maintenance of its FECA case files. Our review of 44 FECA case files found that copies of relevant documentation relating to the personnel specialists' periodic monitoring of the compensation claim was not always present in the file. Specially, we found:

- Four FECA cases files did not have DOL Form CA-1, Federal Notice of Traumatic Injury and Claim for Continuation of Pay/Compensation or CA-2(a), Notice of Recurrence on file.
- A lack of documentation in seven of the FECA case files indicated periods of at least one year where OPM personnel specialists apparently had no contact with the injured employees or DOL's Office of Workers' Compensation Program.
- Two FECA case files did not contain the injured employee's current medical documentation.
- Case files lacked a systematic order, making it difficult to locate all documents relevant to the compensation claim.

**Improvement
Needed in the
Maintenance
of FECA
Case Files**

We also found that OPM's long-term FECA cases may be vulnerable to possible fraudulent payments. We identified 15 FECA cases where either the injured employee or the surviving family member had been receiving FECA payments with very limited verification of continued eligibility.

Additionally, we found that Employee Services was not providing OPM program office managers with their total compensation chargeback costs until the end of the fiscal year, and that these chargeback reports lacked the detailed information associated with those costs.



Statistical Summary of Enforcement Activities

Judicial Actions:

Indictments and Informations.	24
Arrests	13
Convictions.	20

Judicial Recoveries:

Restitutions and Settlements	\$8,202,207
Fines, Penalties, Assessments, and Forfeitures	\$4,014 ¹

Hotline Activity:

HEALTH CARE

Referred to:

OPM Program Offices.	97
FEHBP Insurance Carriers or Providers.	55
Other Federal or State Agencies	11
Informational Only	42
Inquiries Initiated	3
Retained for Further Inquiry	23
Total Received:	231

RETIREMENT

Referred to:

OPM Program Offices.	252
Other Federal or State Agencies	3
Informational Only	95
Inquiries Initiated	1
Retained for Further Inquiry	37
Total Received:	388

(continued on next page)

¹This figure represents criminal fines and criminal penalties returned not to OPM, but to the general fund of the Treasury. It also includes asset forfeitures and court assessments and/or fees resulting from criminal investigations conducted by our office. Many of these criminal investigations were conducted jointly with other Federal agencies, who share the credit for the fines, penalties, assessments, and forfeitures.



Statistical Summary of Enforcement Activities

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

REVOLVING FUND

Referred to:

OPM Program or Contractor Offices	38
Other Federal or State Agencies	0
Informational Only	5
Inquiries Initiated	0
Retained for Further Inquiry	1
Total Received:	44

OTHER

Referred to:

OPM Program or Contractor Offices	145
Other Federal or State Agencies	202
Informational Only	163
Inquiries Initiated	3
Retained for Further Inquiry	6
Total Received:	519

Health Insurance Carrier Notification Activities:

HEALTH CARE

Declined due to:

Lack of OIG Resources	20
Low FEHBP Exposure	54
Allegations Not Substantiated by Carrier	34
Informational Only	17
Inquiries Initiated	5
Retained for Further Inquiry	1,248
Total Received:	1,378

Administrative Sanctions Activity:

FIS Cases Referred for Debarment and Suspension	20
Health Care Debarments and Suspensions Issued	376
Health Care Provider Debarment and Suspension Inquiries	2,342
Health Care Debarments and Suspensions in Effect at End of Reporting Period	33,924



Appendices

APPENDIX I-A Final Reports Issued With Questioned Costs for Insurance Programs

OCTOBER 1, 2015 TO MARCH 31, 2016

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$ 4,486,775
B. Reports issued during the reporting period with findings	14	65,030,513
Subtotals (A+B)	15	69,517,288
C. Reports for which a management decision was made during the reporting period:	13	68,601,524
1. Disallowed costs	N/A	68,810,449
2. Costs not disallowed	N/A	(208,925) ²
D. Reports for which no management decision has been made by the end of the reporting period	2	915,764
E. Reports for which no management decision has been made within 6 months of issuance	0	0

²Represents the net costs, which includes overpayments and underpayments, to insurance carriers. Underpayments are held (no management decision officially made) until overpayments are recovered.



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX I-B

Final Reports Issued With Questioned Costs for All Other Audit Entities

OCTOBER 1, 2015 TO MARCH 31, 2016

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	4	\$79,250
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	0	0
C. Reports for which a management decision was made during the reporting period:	0	0
1. Disallowed costs	N/A	0
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	4	79,250
E. Reports for which no management decision has been made within 6 months of issuance	4	79,250

APPENDIX II

Final Reports Issued With Recommendations for Better Use of Funds

OCTOBER 1, 2015 TO MARCH 31, 2016

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	0	\$ 0
B. Reports issued during the reporting period with findings	1	187,063
Subtotals (A+B)	1	187,063
C. Reports for which a management decision was made during the reporting period:	1	187,063
D. Reports for which no management decision has been made by the end of the reporting period	0	0
E. Reports for which no management decision has been made within 6 months of issuance	0	0

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX III Insurance Audit Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued	Questioned Costs
1A-10-67-15-001	Blue Shield of California in San Francisco, California	October 2, 2015	\$ 47,752
1C-B9-00-15-029	United Healthcare of the Midwest, Inc. in Cypress, California	October 2, 2015	0
1M-0B-00-15-024	Multi-State Plan Program Operations at Anthem Blue Cross Blue Shield of Kentucky in Louisville, Kentucky	October 28, 2015	0
1A-10-85-14-053	CareFirst BlueCross BlueShield in Owings Mills, Maryland	October 28, 2015	657,472
1C-9F-00-15-010	Humana Benefit Plan of Illinois, Inc. in Louisville, Kentucky	October 28, 2015	362,995
1A-99-00-14-068	Pension and Post-Retirement Benefit Costs for a Sample of 24 BlueCross and BlueShield Plans in Owings Mills, Maryland and Washington, D.C.	November 16, 2015	119,166
1J-0E-00-15-016	Federal Employees Dental and Vision Insurance Program as Administered by the Government Employees Health Association, Inc. for contract years 2010 through 2013 in Lee's Summit, Missouri	November 16, 2015	0
1L-0A-00-14-074	Tribal Insurance Processing System as Administered by the U.S. Department of Agriculture's National Finance Center in New Orleans, Louisiana	November 16, 2015	17,335
1C-GF-00-15-002	United Healthcare Benefits of Texas, Inc. in Cypress, California	November 18, 2015	0
1A-10-17-14-037	Health Care Service Corporation in Abilene, Texas	November 19, 2015	35,759,457
1C-A7-00-15-017	Health Net of Arizona, Inc. in Woodland Hills, California	December 9, 2015	261,280
1C-PH-00-16-012	Humana Coverage First of Kansas City in Louisville, Kentucky	January 21, 2016	0
1A-99-00-15-008	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.	January 21, 2016	13,258,298
1D-VT-00-15-026	KPS Health Plans in Bremerton and Seattle, Washington	February 2, 2016	2,028,790



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX III Insurance Audit Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

(Continued)

Report Number	Subject	Date Issued	Questioned Costs
1J-0D-00-15-037	Federal Employees Dental and Vision Insurance Program Operations as Administered by Aetna Dental for contract years 2010 through 2013 in Blue Bell, Pennsylvania	February 16, 2016	\$ 0
1A-10-78-15-040	BlueCross BlueShield of Minnesota in Eagan, Minnesota	February 16, 2016	227,123
1M-0C-00-15-052	Multi-State Plan Program Operations at BlueCross and BlueShield of Michigan in Detroit, Michigan	February 16, 2016	0
1B-38-00-15-057	National Rural Letter Carriers' Association as Sponsor and Administrator for the Rural Carrier Benefit Plan in Alexandria, Virginia	February 26, 2016	11,903
1C-JP-00-15-035	MD-Individual Practice Association, Inc. in Cypress, California	February 26, 2016	11,363,178
1C-WD-00-15-039	Dean Health Plan in Madison, Wisconsin	March 28, 2016	537,762
1C-EA-00-15-051	Capital Health Plan of Tallahassee in Tallahassee, Florida	March 28, 2016	0
1C-IM-00-15-032	GlobalHealth Inc. in Oklahoma City, Oklahoma	March 31, 2016	378,002
TOTALS			\$65,030,513

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX IV Internal Audit Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued
4A-RI-00-16-014	Management Alert of Serious Concerns Related to OPM's Procurement Process for Benefit Programs in Washington, D.C.	October 14, 2015
4A-CF-00-15-027	OPM's FY 2015 Consolidated Financial Statements in Washington, D.C.	November 13, 2015
4A-CF-00-15-028	OPM's FY 2015 Closing Package Financial Statements in Washington, D.C.	November 16, 2015

APPENDIX V Information Systems Audit Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued
1B-44-00-14-065	Information Systems General and Application Controls at the Special Agents Mutual Benefit Association in Rockville, Maryland	October 28, 2015
4A-CI-00-15-011	Federal Information Security Modernization Act of FY 2015 in Washington, D.C.	November 10, 2015
4A-IS-00-15-034	Information Systems General and Application Controls at Key Point Government Solutions in Loveland and Thornton, Colorado	December 9, 2015
1C-3A-00-15-012	Information Systems General and Application Controls at AultCare Health Plan in Canton and Columbus, Ohio	January 21, 2016
1C-76-00-15-021	Information Systems General and Application Controls at Union Health Service, Inc. In Chicago, Illinois	February 16, 2016
1A-10-07-15-048	Information Systems General and Application Controls at BlueCross BlueShield of Louisiana in Baton Rouge, Louisiana	March 28, 2016



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX VI

Special Review Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued
4K-RS-00-16-024	OIG's Special Review of OPM's Management's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group LLC, and its subcontractor, CSIdentity in Washington, D.C.	December 2, 2015

APPENDIX VII

Evaluations and Inspections Reports Issued

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued
4K-RS-00-15-059	OPM's Non-Career Officials' Involvement in the Freedom of Information Act Response Process in Washington, D.C.	November 17, 2015
4K-RS-00-15-050	Evaluation of OPM's Oversight of the Federal Workers' Compensation Program in Washington, D.C.	March 29, 2016

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX VIII Summary of Audit Reports More Than Six Months Old Pending Corrective Action

OCTOBER 1, 2015 TO MARCH 31, 2016

Report Number	Subject	Date Issued
4A-CF-00-05-028	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 1 open recommendation	April 16, 2007
4A-CI-00-08-022	Federal Information Security Management Act for FY 2008 in Washington, D.C.; 19 total recommendations; 2 open recommendations	September 23, 2008
4A-CF-00-08-025	OPM's FY 2008 Consolidated Financial Statements in Washington, D.C.; 6 total recommendations; 1 open recommendation	November 14, 2008
4A-CI-00-09-031	Federal Information Security Management Act for FY 2009 in Washington, D.C.; 30 total recommendations; 2 open recommendations	November 5, 2009
4A-CF-00-09-037	OPM's FY 2009 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 1 open recommendation	November 13, 2009
4A-CF-00-10-015	OPM's FY 2010 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 3 open recommendations	November 10, 2010
4A-CI-00-10-019	Federal Information Security Management Act for FY 2010 in Washington, D.C.; 41 total recommendations; 2 open recommendations	November 10, 2010
1K-RS-00-11-068	Stopping Improper Payments to Deceased Annuitants in Washington, D.C.; 14 total recommendations; 3 open recommendations	September 14, 2011
4A-CI-00-11-009	Federal Information Security Management Act for FY 2011 in Washington, D.C.; 29 total recommendations; 3 open recommendations	November 9, 2011
4A-CF-00-11-050	OPM's FY 2011 Consolidated Financial Statements in Washington, D.C.; 7 total recommendations; 1 open recommendation	November 14, 2011
4A-OP-00-12-013	Information Technology Security Controls of OPM's Audit Report and Receivables Tracking System in Washington, D.C.; 24 total recommendations; 10 open recommendations	July 16, 2012
4A-CF-00-11-067	Administration of the Prompt Payment Act at OPM in Washington, D.C.; 12 total recommendations; 5 open recommendations	September 13, 2012



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX VIII Summary of Audit Reports More Than Six Months Old Pending Corrective Action

OCTOBER 1, 2015 TO MARCH 31, 2016

(Continued)

Report Number	Subject	Date Issued
4A-CI-00-12-016	Federal Information Security Management Act for FY 2012 in Washington, D.C.; 18 total recommendations; 4 open recommendations	November 5, 2012
4A-CF-00-12-039	OPM's FY 2012 Consolidated Financial Statements in Washington, D.C.; 3 total recommendations; 1 open recommendation	November 15, 2012
1K-RS-00-12-031	OPM's Voice over the Internet Protocol Phone System Interagency Agreement with the District of Columbia in Washington, D.C.; 2 total recommendations; 1 open recommendation	December 12, 2012
4A-CF-00-12-066	Assessing the Relevance and Reliability of OPM's Performance Information in Washington, D.C.; 5 total recommendations; 1 open recommendation	April 1, 2013
1A-10-32-12-062	BlueCross BlueShield of Michigan in Detroit, Michigan; 11 total recommendations; 1 open recommendation	July 19, 2013
1H-01-00-12-072	BlueCross and BlueShield's Retail Pharmacy Member Eligibility in 2006, 2007, and 2011 in Washington, D.C.; 11 total recommendations; 10 open recommendations	November 8, 2013
4A-CI-00-13-021	Federal Information Security Management Act for FY 2013 in Washington, D.C.; 16 total recommendations; 5 open recommendations	November 21, 2013
4A-CF-00-13-034	OPM's FY 2013 Consolidated Financial Statements in Washington, D.C.; 1 total recommendation; 1 open recommendation	December 13, 2013
1A-10-17-13-026	Information Systems General and Application Controls at Health Care Service Corporation in Chicago, Illinois; 12 total recommendations; 1 open recommendation	January 28, 2014
4A-CF-00-14-009	OPM's FY 2013 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 1 total recommendation; 1 open recommendation	April 10, 2014
1A-99-00-13-046	Global Non-Covered Ambulance Claims for BlueCross and BlueShield Plans in Washington, D.C.; 4 total recommendations; 1 open recommendation	April 17, 2014
1B-32-00-13-037	Information Systems General and Application Controls at the National Association of Letter Carriers Health Benefit Plan in Ashburn, Virginia; 41 total recommendations; 7 open recommendations	May 6, 2014

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX VIII Summary of Audit Reports More Than Six Months Old Pending Corrective Action

OCTOBER 1, 2015 TO MARCH 31, 2016

(Continued)

Report Number	Subject	Date Issued
1A-10-15-13-058	BlueCross BlueShield of Tennessee in Chattanooga, Tennessee; 16 total recommendations; 4 open recommendations	June 6, 2014
4A-CI-00-14-015	Information Technology Security Controls of OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 5 open recommendations	June 6, 2014
1A-10-67-14-006	Information Systems General and Application Controls at BlueShield of California in San Francisco, California; 16 total recommendations; 1 open recommendation	July 9, 2014
4A-CI-00-14-028	Status of Cloud Computing Environments within the OPM in Washington, D.C.; 3 total recommendations; 3 open recommendations	July 9, 2014
Not Applicable	Review of FIS Background Investigation Process in Washington, D.C.; 3 total recommendations; 3 open recommendations	August 15, 2014
1A-99-00-13-061	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.; 6 total recommendations; 1 open recommendation	August 19, 2014
4A-RI-00-14-036	Information Technology Security Controls of the OPM's BENEFEDS and Federal Long Term Care Insurance Program Information Systems FY 2014 in Washington, D.C.; 10 total recommendations; 2 open recommendations	August 19, 2014
4A-CF-00-14-039	OPM's FY 2014 Consolidated Financial Statements in Washington, D.C.; 4 total recommendations; 3 open recommendations	November 10, 2014
4A-CI-00-14-016	Federal Information Security Management Act for FY 2014 in Washington, D.C.; 29 total recommendations; 17 open recommendations	November 12, 2014
Not Applicable	Management Advisory on Case Number C-14-01328 in Washington, D.C.; 4 total recommendations; 1 open recommendation	December 19, 2014
3A-CF-00-14-050	The 2011 and 2012 Chesapeake Bay Area Combined Federal Campaigns of Central Maryland in Baltimore, Maryland; 24 total recommendations; 15 open recommendations	December 23, 2014
4A-CI-00-14-064	Information Technology Security Controls of the OPM's Dashboard Management Reporting System in Washington, D.C.; 4 total recommendations; 3 open recommendations	January 14, 2015



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX VIII Summary of Audit Reports More Than Six Months Old Pending Corrective Action

OCTOBER 1, 2015 TO MARCH 31, 2016

(Continued)

Report Number	Subject	Date Issued
1A-10-49-14-021	Information Systems General and Application Controls at Horizon BlueCross BlueShield in Newark, New Jersey; 15 total recommendations; 3 open recommendations	February 11, 2015
3A-CF-00-14-049	The 2011 and 2012 Long Island Combined Federal Campaigns in Deer Park, New York; 18 total recommendations; 16 open recommendations	February 11, 2015
1C-U4-00-14-038	The Health Plan of the Upper Ohio Valley, Inc. in St. Clairsville, Ohio; 5 total recommendations; 2 open recommendations	February 20, 2015
3A-CF-00-14-048	The 2011 and 2012 Northern Lights Combined Federal Campaigns in St. Paul, Minnesota; 29 total recommendations; 12 open recommendations	March 23, 2015
4K-RS-00-14-076	OPM's Compliance with the Freedom of Information Act in Washington, D.C.; 3 total recommendations; 2 open recommendations	March 23, 2015
1B-43-00-14-029	Information Systems General and Application Controls and Administrative Expenses at the Panama Canal Area Benefit Plan and its Claims Administrator, AXA Assistance in Panama City, Panama; 12 total recommendations; 7 open recommendations	April 2, 2015
4A-RS-00-13-033	Assessing the Internal Controls over OPM's Retirement Services' Retirement Eligibility and Services Office in Washington, D.C.; 7 total recommendations; 6 open recommendations	April 13, 2015
4A-RI-00-15-013	Information Technology Security Controls of OPM's Multi-State Plan Program Portal in Washington, D.C.; 4 total recommendations; 1 open recommendation	May 11, 2015
4A-CF-00-15-025	OPM's FY 2014 Improper Payments Reporting for Compliance with the Improper Payments Elimination and Recovery Act of 2010 in Washington, D.C.; 4 total recommendations; 4 open recommendations	May 15, 2015
1C-54-00-14-061	Information Systems General and Application Controls at Group Health Cooperative and KPS Health Plans in Tukwila and Bremerton, Washington; 18 total recommendations; 2 open recommendations	May 18, 2015
4A-HR-00-13-055	The Human Resources Solutions' Pricing Methodologies in Washington, D.C.; 5 total recommendations; 5 open recommendations	June 2, 2015
4A-CI-00-15-055	Flash Audit Alert -OPM's Infrastructure Improvement in Washington, D.C.; 2 total recommendations; 2 open recommendations	June 17, 2015

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX VIII Summary of Audit Reports More Than Six Months Old Pending Corrective Action

OCTOBER 1, 2015 TO MARCH 31, 2016

(Continued)

Report Number	Subject	Date Issued
1A-10-33-14-062	Information Systems General and Application Controls at BlueCross and BlueShield of North Carolina in Chapel Hill and Durham, North Carolina; 8 total recommendations; 1 open recommendation	June 18, 2015
1A-99-00-14-069	BlueCross and BlueShield Association's Fraud Information Management System in Washington, D.C. and Chicago, Illinois; 3 total recommendations; 1 open recommendation	July 14, 2015
4A-HR-00-15-018	Information Technology Security Controls of OPM's USA Performance System in Washington, D.C.; 1 total recommendation; 1 open recommendation	July 20, 2015
1A-99-00-14-046	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 2 open recommendations	July 29, 2015
4A-RI-00-15-019	Information Technology Security Controls of the OPM's Annuitant Health Benefits Open Season System in Washington, D.C.; 7 total recommendations; 6 open recommendations	July 29, 2015
4A-HR-00-15-015	Information Technology Security Controls of OPM's GP Plateau Baseline 6 Learning Management System in Washington, D.C.; 12 total recommendations; 4 open recommendations	July 31, 2015
1C-QA-00-14-045	Independent Health Plan in Buffalo, New York; 3 total recommendations; 2 open recommendations	August 12, 2015
1C-E3-00-15-020	Information Systems General and Application Controls at Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. in Silver Spring, Maryland; 8 total recommendations; 5 open recommendations	August 28, 2015
1C-22-00-14-071	Aetna Health Fund in Blue Bell, Pennsylvania; 2 total recommendations; 2 open recommendations	August 31, 2015
1C-51-00-14-066	Health Insurance Plan of Greater New York in New York, New York; 3 total recommendations; 2 open recommendations	August 31, 2015
4A-RS-00-15-014	Special Review of OPM's Quality Assessment of USIS's Background Investigations in Washington, D.C.; 1 total recommendation; 1 open recommendation	September 22, 2015



Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS

APPENDIX IX

Most Recent Peer Review Results

OCTOBER 1, 2015 TO MARCH 31, 2016

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

Subject	Date of Report	Result
System Review of the Amtrak Office of Inspector General Audit Organization <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	January 29, 2016	Pass ³
System Review Report for the U.S. Office of Personnel Management's Office of the Inspector General Audit Organization <i>(Issued by the Office of the Special Inspector General for Afghanistan Reconstruction)</i>	September 22, 2015	Pass ³
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the Railroad Retirement Board <i>(Issued by the Office of the Inspector General, U.S. Office of Personnel Management)</i>	August 13, 2014	Compliant ⁴
Quality Assessment Review of the Investigative Operations of the Office of the Inspector General for the U.S. Office of Personnel Management <i>(Issued by the Office of Inspector General, U.S. Department of State)</i>	June 21, 2013	Compliant ⁴

³A peer review rating of **Pass** is issued when the reviewing Office of Inspector General concludes that the system of quality control for the reviewed Office of Inspector General has been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The Peer Review does not contain any deficiencies or significant deficiencies.

⁴A rating of **Compliant** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.

Appendices

OFFICE OF THE INSPECTOR GENERAL SEMIANNUAL REPORT TO CONGRESS



APPENDIX X Investigative Recoveries OCTOBER 1, 2015 TO MARCH 31, 2016

OIG Case Number	Case Category	Action	OPM Recovery (Net)	Total Recovery Amount (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2011 00723	Federal Investigative Services Fraud	Criminal	\$ 91,124	\$ 91,124	\$ 100
I-15-01248	Federal Investigative Services Fraud	Criminal	0	0	1,010
TOTAL	Federal Investigative Services Fraud		\$ 91,124	\$ 91,124	\$1,110
I 2011 00829	Healthcare Fraud	Civil	1,073,605	102,060,000	0
I-12-00291	Healthcare Fraud	Civil	4,807,992	237,000,000	0
I-13-00449	Healthcare Fraud	Civil	42,416	2,091,400	0
I-13-01055	Healthcare Fraud	Civil	24,250	400,000	0
I-15-00196	Healthcare Fraud	Civil	1,640	26,374	0
C-15-00334	Healthcare Fraud	Civil	30,824	31,777	0
I-15-01544	Healthcare Fraud	Civil	943,065	21,523,047	0
I-15-01546	Healthcare Fraud	Civil	39,233	4,736,133	0
I-15-01548	Healthcare Fraud	Civil	63,332	6,529,078	0
I-15-01549	Healthcare Fraud	Civil	4,443	2,100,000	0
I-15-01549	Healthcare Fraud	Civil	2,639	1,600,000	0
I-15-01551	Healthcare Fraud	Civil	195,452	3,781,566	0
I-15-01552	Healthcare Fraud	Civil	125	10,000	0
C-16-00108	Healthcare Fraud	Civil	36,951	38,094	0
I-16-00109	Healthcare Fraud	Civil	115,957	2,243,510	0
I-16-00109	Healthcare Fraud	Civil	0	2,270,236	0
I-14-00280	Healthcare Fraud	Criminal	1,449	1,449	0
I-12-00455	Healthcare Fraud	Criminal	257,000	257,000	100
I-12-00455	Healthcare Fraud	Criminal	0	0	100
I-13-00596	Healthcare Fraud	Criminal	137,893	137,893	304
I-14-00325	Healthcare Fraud	Criminal	0	0	600
I-14-00325	Healthcare Fraud	Criminal	15,556	1,297,645	500
I-15-00031	Healthcare Fraud	Criminal	0	27,108	100
I-15-00281	Healthcare Fraud	Criminal	93,596	233,578	100
TOTAL	Healthcare Fraud		\$7,887,418	\$388,395,888	\$1,804
I-13-00319	Retirement Fraud	Civil	110,328	110,328	0
I 2011 00238	Retirement Fraud	Criminal	30,058	194,486	1,000
I-14-00816	Retirement Fraud	Criminal	83,279	221,947	100
TOTAL	Retirement Fraud		\$ 223,665	\$ 526,761	\$1,100
GRAND TOTAL			\$8,202,207	\$389,013,773	\$4,014

Note: Cases that are listed multiple times indicate there were multiple subjects.



Index of Reporting Requirements

	Page
Section 4 (a) (2):	Review of legislation and regulations. No Activity
Section 5 (a) (1):	Significant problems, abuses, and deficiencies 1-38
Section 5 (a) (2):	Recommendations regarding significant problems, abuses, and deficiencies 1-22
Section 5 (a) (3):	Recommendations described in previous semiannual reports on which corrective action has not been completed No Activity
Section 5 (a) (4):	Matters referred to prosecutive authorities 23-38
Section 5 (a) (5):	Summary of instances where information was refused during this reporting period. No Activity
Section 5 (a) (6):	Listing of audit reports issued during this reporting period. 41-44
Section 5 (a) (7):	Summary of particularly significant reports 1-38
Section 5 (a) (8):	Audit reports containing questioned costs 41-45
Section 5 (a) (9):	Audit reports containing recommendations for better use of funds No Activity
Section 5 (a) (10):	Summary of unresolved audit reports issued prior to the beginning of this reporting period 47-51
Section 5 (a) (11):	Significant revised management decisions during this reporting period. No Activity
Section 5 (a) (12):	Significant management decisions with which the OIG disagreed during this reporting period No Activity
Section 5 (a) (14) (A):	Peer reviews conducted by another OIG 52
Section 5 (a) (16):	Peer reviews conducted by the OPM OIG 52



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