



# SEMIANNUAL REPORT to CONGRESS

April 1, 2017 - September 30, 2017



United States  
Office of Personnel Management  
**OFFICE OF THE INSPECTOR GENERAL**

# OFFICE OF THE INSPECTOR GENERAL



## Indicators

### Financial Impact:

Audit Recommendations for Recovery of Funds .....	\$9,613,432
Management Commitments to Recover Funds .....	\$9,898,966
Recoveries Through Investigative Actions .....	\$7,804,376

*Note: OPM management commitments for recovery of funds during this reporting period reflect amounts covering current and past reporting periods audit recommendations. Further, management commitments to recover funds for some of the recommendations made during this reporting period will be decided in future reporting periods.*

### Accomplishments:

Audit Reports Issued .....	21
Evaluations Reports Issued .....	2
Investigations Closed .....	58
Indictments and Informations .....	56
Arrests .....	24
Convictions .....	20
Hotline Contacts and Complaints Received .....	992
Hotline Contacts and Complaints Closed .....	983
Health Care Provider Debarments and Suspensions Issued .....	475
Health Care Provider Debarment and Suspension Inquiries .....	2,541



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# Message from the Acting Inspector General

President Trump's Administration has expressed a zealous commitment to curbing improper payments in all Federal programs and agencies. To that end, I would like to discuss the various legislative proposals that—if enacted—could contribute significantly to this goal and would assist the U.S. Office of Personnel Management (OPM) Office of the Inspector General (OIG) in combating waste, fraud, and abuse within OPM programs and operations.

First and foremost is the amendment to the Anti-Kickback Statute that I discussed in detail in our last Semiannual Report to Congress. The OPM-administered Federal Employees Health Benefits Program (FEHBP) is explicitly denied the protections of the Anti-Kickback Statute, which prohibits medical providers from accepting a bribe or other remuneration in exchange for making a medical decision or referral. The tax dollars spent on the FEHBP are just as valuable as those spent on Medicare, Medicaid, TRICARE, and other Federal health care programs. Yet the law denies the Federal Government recourse to the Anti-Kickback Statute in seeking to recover FEHBP funds when doctors take bribes to generate claims under the FEHBP. Our office continues to work with Congress to address this gross injustice.

Another proposal that our office is exploring is to create an FEHBP anti-fraud program modeled after the Health Care Fraud and Abuse Control Program (HCFAC), which is under the joint direction of the Attorney General and the Secretary of the U.S. Department of Health and Human Services (HHS), acting through HHS's OIG. HCFAC is a dynamic program designed to employ health care fraud recoveries—including criminal fines, forfeitures, civil settlements and judgements, and administrative penalties—to fund enforcement actions.

Health care fraud schemes often target multiple Federal programs and as a result, our office often works closely with law enforcement partners, including the HHS OIG, to investigate these schemes and hold the

*(continued on next page)*



perpetrators accountable. When a joint case implicating FEHBP funds results in recoveries, the FEHBP's trust fund receives up to the amount that it was defrauded and any resulting lost investment income associated with those funds. However, any penalties or fines associated with the FEHBP's losses (such as the treble damages awarded under the False Claims Act) are deposited into the HCFAC account, to be used in support of the HCFAC activities undertaken by DOJ, HHS, and the HHS OIG.

We believe that FEHBP-related damages should instead be invested back into the FEHBP. Those funds could be used by OPM to increase its fraud prevention efforts, and by the OPM OIG to increase its investigative and oversight capabilities. This would ensure that those who attempt to defraud the FEHBP bear the costs of FEHBP enforcement activities.

We will continue to discuss both of these proposals with our Congressional committees and the Office of Management and Budget, and I look forward to the day when we can report that both have been enacted.



**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.





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# 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 \$50 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 their costs from the premiums they receive each year. If the premiums are not sufficient to cover the costs, the community-rated carriers suffer 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 six final audit reports on organizations participating in the FEHBP which contained recommendations for monetary adjustments of \$9.6 million due to the OPM-administered trust funds.



## 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 effective prior to July 2015 required 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 (MLR) Audits*

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

*Medical Loss Ratio 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, which was amended in 2015 to require only one rather than two SSSGs.

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. 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 (MSP Program) 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 consultation 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. In 2017, the MSP Program universe consists of approximately 23 state-level issuers covering 22 states. 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 three final audit reports on community-rated health plans and MSP issuers and recommended \$56,890 in monetary recoveries. Two of the three final reports also recommended adjustments to MLR credits totaling \$505,172. Because there is no money involved in the MSP Program contract, these recoveries cannot be returned to the FEHBP. Report summaries are provided below to highlight notable audit findings for the MSP issuer and FEHBP carriers.

## Arkansas BlueCross BlueShield

LITTLE ROCK, ARKANSAS

Report No. 1M-OF-00-16-058

APRIL 14, 2017

The BlueCross BlueShield Association, on behalf of participating BlueCross BlueShield (BCBS) plans, entered into a contract with OPM to participate in the MSPP. Along with its participating licensees, the Association offers 148 MSP options in 33 states and the District of Columbia. Arkansas BlueCross BlueShield (ABCBS) was one of 40 BCBS plans, or State-Level Issuers, participating in the MSP Program in 2015.

ABCBS is the largest health insurer in Arkansas. In addition to offering the three MSP options (Bronze, Silver, and Gold) on the Federally Facilitated Marketplace, they offer health and dental insurance policies for individuals and families with a full portfolio of health management tools and resources designed to improve the health of all their members, no matter where they fall on the care continuum. ABCBS is a not-for-profit mutual insurance company.

Areas of Non-Compliance with OPM's Contract Result in a Lack of Efficiency and Effectiveness in the Enrollment of MSPP Members

The audit covered ABCBS's compliance with the 2015 Contract and applicable regulations. Our auditors identified two areas of non-compliance.

Specifically, we found that:

- ABCBS did not accurately process a Healthcare Insurance Casework System case; and
- ABCBS's automated system failed to send a Summary of Benefits and Coverage (SBC) to all enrollees and members from January to June of 2015. ABCBS also did not attempt to obtain valid addresses for members whose SBC's were subsequently sent and returned as undeliverable.

ABCBS agreed with all of the audit findings and implemented corrective actions to address them. This audit is closed.

## UPMC Health Plan

PITTSBURGH, PENNSYLVANIA

Report No. 1C-8W-00-16-041

MAY 3, 2017

UPMC Health Plan (Plan) has participated in the FEHBP since 2000, and provides health benefits to FEHBP members in a 28-County area in Western Pennsylvania. The audit covered the Plan's 2012 and 2013 FEHBP premium rate build-up and MLR submissions. During this period, the FEHBP paid the Plan approximately \$164.4 million in premiums.

Our audit identified an overstated MLR credit of \$68,885 for contract year 2013. Specifically, we found that the Plan:

- Erroneously excluded the High-Deductible Health Plan allocations for prescription drug rebates, health care receivables, quality health improvement expenses, and fraud reduction expenses in the 2012 and 2013 MLR submissions;
- Included medical claims not allowed by the FEHBP and included claims for ineligible dependents in the incurred claims data used to calculate the 2013 MLR;
- Incorrectly coordinated the payment of a medical claim with the Centers for Medicare and Medicaid Services and included the inaccurately paid claim in the incurred claims data used to calculate the 2013 MLR; and
- Could not support the tax and fraud reduction expenses reported in the 2013 MLR submission.



Although the 2013 MLR submission errors also affected the 2012 MLR calculation, the findings did not result in a penalty for this contract year.

The Plan either agreed with the audit findings or agreed to implement corrective actions to address them. OPM is still in the process of resolving this audit and has closed three of the five audit recommendations.

**Errors in the 2013 MLR Calculation Resulted in a \$68,885 Overstated MLR Credit**

**Union Health Service, Inc.**

CHICAGO, ILLINOIS

Report No. 1C-76-00-16-042

MAY 10, 2017

Union Health Services, Inc. (Plan) has participated in the FEHBP since 1975, and provides health benefits to FEHBP members in the Chicago area. The audit covered the Plan’s 2012 and 2013 FEHBP premium rate build-up and MLR submissions. During this period, the FEHBP paid the Plan approximately \$9.3 million in premiums.

Our audit identified defective pricing to the FEHBP totaling \$56,890 in 2013, including \$4,270 for lost investment income. Although defective pricing was also identified in 2012, the amount questioned was not material enough to result in an MLR penalty. Additionally, the audit identified an understated MLR credit totaling \$436,287 for 2013. Finally, we determined that the Plan did not submit its pharmacy claims data in accordance with the requirements of Carrier Letter 2014-18.

**Non-Compliance with the FEHBP Rules and Regulations and Errors in the 2013 MLR Calculation Resulted in Program Overcharges of \$56,890 and an Understated MLR Credit of \$436,287**

Specifically, we found that the Plan:

- Applied an incorrect step-up factor to the FEHBP’s 2012 rates;
- Erroneously modified its 2012 and 2013 reconciled rates with adjustments that were already captured in its proposed rates. It also did not provide sufficient support for its transplant benefit costs, and it erroneously charged additional benefit costs for a growth hormone therapy benefit, which was already covered as part of the Plan’s base benefit package;
- Used an incorrect number of member months to determine the 2013 office visit adjustment and other benefit variances loadings; and
- Submitted incomplete pharmacy claims data for its 2013 MLR submission, which impacted the MLR numerator.
- Finally, we adjusted the 2013 MLR denominator for the 2013 defective pricing amount of \$52,620.

The Plan agreed with some of the findings and disagreed with other findings. However, its responses to our final report were sufficient to close all of the audit recommendations. This audit is, therefore, closed.

**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. Experience-rated HMOs also 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 six experience-rated final audit reports. Our experience-rated audits normally address health benefit payments, miscellaneous payments and credits, administrative expenses, cash



management activities, and/or fraud and abuse program activities. In these reports, our auditors recommended that the plans return \$9.48 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 underwrite and process the health benefit claims of its Federal subscribers. Approximately 64 percent of all FEHBP subscribers are enrolled in BCBS plans.

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.

We issued three BCBS experience-rated reports during the reporting period. Our auditors identified \$9.46 million in questionable costs charged to the FEHBP contract. Summaries of these final reports are provided below and on pages 11 - 16 (as part of the Information Systems Audits) to highlight our notable audit findings.

### Anthem Inc.

MASON, OHIO

Report No. 1A-10-18-16-009

MAY 30, 2017

Anthem Inc. (Anthem) includes 14 BlueCross and/or BlueShield plans in various states. Our audit of the FEHBP operations at Anthem covered administrative expenses

## Auditors Question Over \$3 Million in Health Benefit Refunds and Recoveries, Administrative Expenses, and Lost Investment Income

from 2012 through 2014, as well as miscellaneous health benefit payments and credits and cash management activities from January 2012 through June 2015. We also reviewed Anthem's fraud and abuse program activities and practices from January 2015 through September 2015. In addition, we expanded our audit scope to include questionable cost centers that were potentially charged to the FEHBP in 2010, 2011 and 2015, as part of administrative expenses. For contract years 2012 through 2014, Anthem processed approximately \$17 billion in FEHBP health benefit payments and charged the FEHBP \$901 million in administrative expenses for these 14 BCBS plans.

We questioned \$3,024,520 in health benefit refunds and recoveries, net administrative expense overcharges, and lost investment income (LII). Our auditors also identified a procedural finding regarding Anthem's fraud and abuse program. The monetary findings included the following:

- \$1,148,257 for health benefit refunds and recoveries that had not been returned to the FEHBP and \$5,979 for applicable LII;
- \$1,147,874 for administrative expense charges that were unallowable and/or did not benefit the FEHBP and \$48,072 for LII on these charges; and,
- \$632,790 for plan employee net pension cost overcharges and \$41,548 for LII on the overcharges.

For the procedural finding regarding the Plan's fraud and abuse program, we determined that Anthem and the FEP Director's Office are not in full compliance with the communication and reporting requirements for fraud and abuse cases set forth in the FEHBP contract and Carrier Letter 2014-29. Specifically, Anthem and the FEP Director's Office did not report, or did not timely report, all fraud and abuse cases to OPM's OIG. Without awareness of Anthem's probable fraud and abuse issues, we cannot investigate the impact of these potential issues on the FEHBP.



Anthem agreed with \$2,194,736 of the questioned amounts and returned these funds to the FEHBP. Regarding the procedural finding, the Association and Anthem generally disagreed with the finding but have implemented corrective actions.

## BlueCross BlueShield of Rhode Island

PROVIDENCE, RHODE ISLAND

Report No. 1A-10-60-16-056

JULY 27, 2017

Our audit of the FEHBP operations at BlueCross BlueShield of Rhode Island (Plan) covered administrative expenses from 2011 through 2015, as well as miscellaneous health benefit payments and credits and cash management activities from January 2013 through March 2016. We also reviewed the Plan's fraud and abuse program activities and practices from January 2015 through March 2016. For contract years 2011 through 2015, the Plan processed approximately \$359 million in FEHBP health benefit payments and charged the FEHBP \$32 million in administrative expenses.

BCBS of  
Rhode Island  
Returned the  
Questioned  
Amounts of  
\$466,401  
to the FEHBP

We questioned \$466,401 in hospital settlement recoveries, administrative expense overcharges, and LII. The Plan agreed with our monetary findings and returned all of the questioned amounts to the FEHBP.

## 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 two audit reports on employee organization plans during this reporting period. The following is a summary of the notable findings from one of the two audit reports.

## Special Agents Mutual Benefit Association

ROCKVILLE, MARYLAND

Report No. 1B-44-00-17-002

SEPTEMBER 29, 2017

The Special Agents Mutual Benefit Association (SAMBA) is the sponsor and administrator of the SAMBA Health Benefit Plan (Plan). The Plan is an experience-rated fee-for-service employee organization plan, offering high and standard options, with a preferred provider organization. Plan enrollment is open to all Federal employees and annuitants who are eligible to enroll in the FEHBP. All employees and annuitants who enroll in the Plan automatically become members of SAMBA.

The objective of our audit was to determine whether SAMBA handled FEHBP funds in accordance with the FEHBP contract and applicable laws and regulations concerning cash management in the FEHBP. Our audit covered SAMBA's cash management activities and practices related to FEHBP funds from 2014 through June 30, 2016, for the SAMBA Health Benefit Plan.

Auditors  
Question  
\$23,679  
in Cash  
Management  
Activities

In total, we questioned \$23,679 in cash management activities. Specifically, we determined that SAMBA held net excess FEHBP funds of \$23,679 in the Plan's dedicated FEHBP bank account as of June 30, 2016. SAMBA agreed with this

finding and immediately returned these net excess funds to the FEHBP.



## 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.

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

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### HealthPartners

MINNEAPOLIS, MINNESOTA

Report No. 1D-V3-00-17-005

SEPTEMBER 29, 2017

HealthPartners (Plan) is an experience-rated HMO offering health benefits to Federal enrollees and their families. Plan enrollment is open to all Federal employees and annuitants who live or work in the Plan’s service area, which includes Minnesota and the surrounding communities in Western Wisconsin, Northern Iowa, and Eastern North and South Dakota.

The audit covered the Plan’s cash management activities and practices related to FEHBP funds from 2014 through June 30, 2016. Specifically, we reviewed the Plan’s letter of credit account (LOCA) drawdowns, interest income

HealthPartners  
Handled  
FEHBP Funds  
Properly

transactions, and dedicated FEHBP bank account activity and balances to determine if the Plan handled FEHBP funds in accordance with the contract and applicable laws and regulations concerning cash management in the FEHBP.

Our auditors identified no significant findings pertaining to the Plan’s cash management activities and practices. Overall, we concluded that the Plan handled FEHBP funds in accordance with the FEHBP contract and applicable laws and regulations concerning cash management in the FEHBP.



# Information Systems Audits

OPM manages a wide portfolio of information systems to help fulfill its mission. OPM systems support the management of background investigations for applicants for Federal employment, and Federal employees, the processing of retirement benefits, and multiple Government-wide human resources services. OPM also contracts with private health insurance carriers to provide health benefits to millions of current and former Federal employees. The increasing frequency and sophistication of cyber-attacks on both the private and public sectors emphasize the need for OPM and its contractors to implement and maintain effective cybersecurity programs. Our information technology audits identify areas for improvement in the auditee's cybersecurity posture and our recommendations provide tangible strategies to correct those 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 improper payments be returned to OPM.

Several of the more notable audit reports issued during this period are summarized below.

## Information Systems General and Application Controls at Dean Health Plan

MADISON, WISCONSIN

Report No. 1C-WD-00-16-059

JUNE 05, 2017

Our information technology (IT) audit focused on the claims processing applications used to adjudicate FEHBP claims for Dean Health Plan (DHP) members, as well as the various processes and IT systems used to support these applications.

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

### Security Management

DHP has established an adequate security management program.

### Access Controls

DHP has implemented both physical and logical access controls to prevent unauthorized access to its facilities and to sensitive information.

### Network Security

DHP has implemented an incident response and network security program. However, DHP has not documented and approved a firewall configuration standard. Without

Improvements  
Still Needed  
for Network  
Security and  
Configuration  
Management

a firewall configuration standard DHP cannot routinely review its firewalls for compliance against an approved baseline. DHP also has systems running software that is unsupported by the vendor, and DHP

does not have a technical control in place to prevent unauthorized devices from accessing its network.

### Configuration Management

DHP has developed configuration management policies and procedures. However, DHP has not documented and approved configuration standards for its systems. Without configuration standards DHP cannot routinely review its systems to ensure a secure configuration.

### Contingency Planning

DHP has established a risk-based contingency program with documented plans that identify critical systems and contain detailed recovery procedures. These plans and procedures are regularly reviewed and tested.



## Claims Adjudication

DHP has implemented controls in its claims adjudication process to ensure that FEHBP claims are processed accurately.

## Security Assessment and Authorization Methodology

WASHINGTON, DC

Report No. 4A-CI-00-17-014

JUNE 20, 2017

Since fiscal year (FY) 2014, the number of OPM information systems without a current and valid Security Assessment and Authorization (Authorization) was significant enough to warrant reinstating a material weakness related to this issue. In FY 2015, OPM placed a moratorium on all Authorization activity, further weakening the agency's security posture. In FY 2016, OPM initiated an "Authorization Sprint" (Sprint) in an effort to get all of the agency's systems compliant with the Authorization requirements. We performed this audit to evaluate OPM's progress in addressing the material weakness.

Our objectives were to review OPM's current Authorization methodology and to evaluate the Authorization packages completed during the Sprint. We focused our efforts on reviewing the Authorization package for OPM's primary general support system, the Local Area Network / Wide Area Network (LAN/WAN).

OPM has dedicated significant resources toward re-authorizing the systems that were neglected as a result of the 2015 Authorization moratorium. Although the program has notably improved, the deficit left by the moratorium continues to hamper the agency. We detected significant problems with the Authorization packages prepared during the Sprint, and there is still significant effort needed to stabilize the Authorization program. Of primary concern is the fact that the assessors performing the Sprint activity did not have access to enough accurate and complete information to make valid risk-based decisions about the systems' security posture. Our specific concerns include:

- The LAN/WAN system security plan (SSP) was missing relevant data about hardware, software, minor systems, and inherited controls. Additionally, the LAN/WAN SSP also failed to appropriately address several relevant controls, labeled "not applicable."
- Deficiencies in the security control testing performed as part of the LAN/WAN Authorization process likely prevented the assessors from identifying security vulnerabilities that could have been detected with an appropriately thorough test.
- The security weaknesses detected during the LAN/WAN Authorization were not appropriately tracked in a Plan of Action and Milestones document.
- Critical elements were missing from many of the other Authorization packages prepared during the Sprint.

OPM has acknowledged the deficiencies of the Sprint Authorization packages, and explained that its intent was to obtain an initial level of compliance with Authorization requirements. It has already initiated a secondary review of the LAN/WAN Authorization in order to address the deficiencies, and we will monitor this effort closely. However, at this time, 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.

## Global Duplicate Payments for BlueCross and BlueShield Plans

WASHINGTON, D.C.

Report No. 1A-99-00-16-043

JUNE 21, 2017

We conducted a limited scope performance audit to determine whether the BCBS plans charged costs to the FEHBP and provided services to the FEHBP members in accordance with the terms of the BCBS Association's (Association) contract with OPM. Specifically, our objective was to determine whether the BCBS plans complied with contract provisions relative to duplicate claim payments.

The audit covered health benefit payments from June 2013 through March 2016, as reported in the Association's



Government-wide Service Benefit Plan FEP Annual Accounting Statements. We performed various computer searches on BCBS claims data to identify potential duplicate payments charged to the FEHBP during the audit scope.

Our audit identified \$5,967,324 in duplicate claim overpayments. The majority of the claim payment errors were related to manual processing errors, which we believe

### Auditors Question Over \$5.9 Million in Duplicate Claim Payments

are indicative of systemic internal control problems. Our recurring audits continue to identify claim payment errors resulting from manual processing errors, and we therefore recommend that the OPM contracting

office ensure the corrective actions in this report are promptly implemented.

We do not believe that the BCBS plans have exercised due diligence in implementing controls to eliminate erroneous duplicate claim payments. As a result, we concluded that these claims were not paid in good faith, and therefore were not paid in compliance with the terms of the Association's contract with OPM.

## Information Technology Security Control of OPM's Federal Financial System

WASHINGTON, D.C.

Report No. 4A-CF-00-17-044

SEPTEMBER 29, 2017

The Federal Financial System (FFS) is part of the Benefits Financial Management System (BFMS), which is one of the OPM's major IT systems. We completed a performance audit of FFS to ensure that the system's security controls meet the standards established by the Federal Information Security Modernization Act (FISMA), the National Institute of Standards and Technology (NIST), the Federal Information System Controls Audit Manual, and OPM's Office of the Chief Information Officer (OCIO).

FFS is a commercial software product developed and supported by a third-party vendor. This vendor had historically developed and released updated versions of the FFS software, but OPM has not had a support contract in place to receive these updates since 2002. In addition to the security risks inherent in operating an application that no longer receives updates, there are two other critical issues OPM faces by continuing to use the unsupported FFS application. First, FFS and BFMS inherit the majority of their security controls from the general support systems that host these applications (OPM's mainframe and the Local Area Network/Wide Area Network). As the support systems' technology continues to evolve, the FFS application may no longer be compatible with those host environments. This could either make FFS obsolete, or it could increase the security risks of OPM as a whole should the agency refrain from updating the support systems in order to keep the FFS application operational. Second, OPM's financial reporting needs continue to evolve, and the core functionality of the FFS application cannot be updated to meet these needs.

Our audit of the IT security controls of FFS and its host system, BFMS, also determined that:

- A Security Assessment and Authorization (Authorization) of BFMS was completed in 2016.
- OPM has not fully completed a Privacy Impact Assessment for BFMS.
- The BFMS System Security Plan generally follows the OCIO template, but there were instances where the documentation was incomplete or out of date.
- The BFMS risk assessment did not include an assessment of all known control weaknesses.
- OPM could improve the continuous monitoring of the security controls of BFMS.
- A contingency plan was developed for BFMS and is generally in compliance with NIST SP 800-34 Revision 1 and OCIO guidance. However, the plan is missing several pieces of critical information.
- The BFMS Plan of Action and Milestones (POA&M) documentation did not include all required information and known weaknesses. In addition, most POA&M remediation activities are more than six months past their scheduled completion dates.



## 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.

### FY 2016 Improper Payments Reporting

WASHINGTON, D.C.

Report No. 4A-CF-00-17-012

MAY 11, 2017

On July 22, 2010, and January 10, 2013, the President signed into law the Improper Payments Elimination and Recovery Act of 2010 (IPERA) and the Improper Payments Elimination and Recovery Improvement Act of 2012 (IPERIA), respectively, which amended the Improper Payments Information Act of 2002. IPERIA redefined the definition of "significant improper payments" and strengthened executive branch agency reporting requirements.

OPM is in Compliance with IPERA Requirements for FY 2016

The U.S. Office of Management and Budget (OMB) requires agency Inspectors General to review their agency's Agency Financial Report (AFR) for compliance with IPERA's requirements.

The IPERA criterion for compliance includes requires agencies to:

- Publish an AFR or Performance and Accountability Report (PAR) for the most recent FY and post that report and any accompanying materials required by OMB on the agency website;
- Conduct a program specific risk assessment for each program or activity that conforms with Section 3321 of Title 31 United States Code (if required);
- Publish improper payment estimates for all programs and activities identified as susceptible to significant improper payments under its risk assessment (if required);

- Publish programmatic corrective action plans in the AFR or PAR (if required);
- Publish and meet annual reduction targets for each program assessed to be at risk and estimated for improper payments (if required and applicable); and,
- Report a gross improper payment rate of less than 10 percent for each program and activity for which an improper payment estimate was obtained and published in the AFR or PAR.

We conducted an audit to determine if OPM is in compliance with the Improper Payments Information Act. As a result, we found that OPM was in compliance with IPERA's six requirements for FY 2016.

For IPERIA's additional reporting requirements, we determined that OPM is not in compliance with IPERIA's *Do Not Pay Initiative* reporting requirements for FY 2016. Specifically, Retirement Services:

- Did not report the Do Not Pay Initiative results for the Do Not Pay reporting tool in the alternative reporting table, "*FY 2016 Death Match Statistics*," in the FY 2016 AFR.
- Could not provide documentation to support more than 17,000 backlogged records in the Do Not Pay Portal.
- Could not provide documentation to support the analysis and conclusion from their review of each of the 17,000 backlogged records that were investigated.

In addition, we identified three areas, internal control assessments, risk assessments, and improper payment root causes, where OPM can improve on its oversight controls over improper payments reporting.

## OPM's Purchase Card Program

WASHINGTON, D.C.

Report No. 4A-OO-00-16-046

JULY 7, 2017

Our auditors conducted a performance audit of OPM's Purchase Card Program. The objective of our audit was to determine if the Office of Procurement Operations' (OPO) internal controls for purchase cards were effectively developed and implemented to prevent and detect purchase card fraud, misuse, or abuse.

OPO is responsible for the administration of OPM's purchase card program, to include effectively managing card issuance and providing oversight over the program to ensure compliance with all authoritative guidance.

We determined that OPO needs to strengthen its controls over its purchase card operation's processes in the following five areas:

- Of the 164 active purchase cards in OPM at the time of our audit, we found that 23, which had been issued to a former agency program coordinator, were not immediately canceled when the employee separated from OPM. Five of the cards were used for purchases, totaling \$54,212, by unauthorized users.

Transactions  
 Totaling  
 \$54,212  
 Made By  
 Unauthorized  
 Users

- For agency reporting, we found that OPO could not provide documentation to support the \$238,400 outstanding balance reported in OPM's FY 2015 AFR. In addition, OPO's FY 2016, third quarter statistical report was incomplete.
- OPO had not blocked, in JPMorgan Chase's PaymentNet, seven merchant category codes for items that were restricted or prohibited from being purchased with a Government purchase card. None of the restricted and prohibited codes were used during the scope of the audit.
- Training records for purchase card program participants were either outdated or incomplete.
- We found no evidence that cardholders were using their Government purchase card to purchase items that did not represent a legitimate business need; however, OPO's internal controls need improvement in the areas of: transaction documentation retention; payment of sales taxes; and reallocating and approving transactions in OPM's financial system.

OPO concurred with all 12 of our recommendations.



## Special Audits

In addition to health insurance and retirement programs, OPM administers various other benefit programs for Federal employees which include:

- Federal Employees' Group Life Insurance (FGLI) 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.

The following audit reports were issued during the reporting period.

### Federal Employees Dental and Vision Insurance Program Operations as Administered by UnitedHealthcare Insurance Company for Contract Years 2014 and 2015

COLUMBIA, MARYLAND

Report No. 1J-OB-00-16-063

SEPTEMBER 29, 2017

The Federal Employee Dental and Vision Benefits Enhancement Act of 2004 established a supplemental dental and vision benefits program for Federal employees, retirees, 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 UnitedHealthcare Insurance Company to administer vision benefits under the FEDVIP.

OPM has the overall responsibility to maintain the FEDVIP website, act as a liaison and facilitate the promotion of

the FEDVIP through Federal agencies, provide timely responses to carrier requests for information and assistance, and perform functions typically associated with insurance commissions, such as the review and approval of rates, forms, and educational materials.

The main objective of the audit was to determine whether costs charged to the FEDVIP and services provided to its members for contract years 2014 and 2015 were in accordance with the terms of the Contract and applicable Federal regulations. Additionally, we conducted a limited scope review to determine if a transfer of unreimbursed expenses for FEDVIP operations from contract years 2007 to 2013 was correctly calculated and allowable.

UnitedHealthcare  
Insurance  
Company  
Did Not  
Coordinate  
Benefits  
with FEHBP  
Carriers

The results of our review showed that the Plan had sufficient policies and procedures in place to ensure that it accurately reported its annual accounting statement to OPM and accurately developed its FEDVIP rate proposals for 2014 and 2015.



Additionally, we found that the Plan’s proposed transfer of funds for unreimbursed FEDVIP expenses from contract years 2007 to 2013 was allowable, accurate, and in compliance with the prior contract.

However, the audit determined that the Plan did not coordinate benefits with other Federal Employees Health Benefits Program carriers as is required by the Contract.

**National Association of Letter Carriers  
Health Benefit Plan’s Pharmacy Operations  
as Administered by Caremark  
for Contract Years 2012 through 2014**

SCOTTSDALE, ARIZONA

Report No. 1H-01-00-16-045

SEPTEMBER 29, 2017

The National Association of Letter Carriers Health Benefit Plan (NALC) participates in the FEHBP and contracted with a Pharmacy Benefit Manager (PBM), CaremarkPCS, L.L.C. (Caremark), to provide pharmacy benefits and services to its members for contract years 2012 through 2014. PBMs are primarily responsible for processing and paying prescription drug claims. The services provided typically include retail pharmacy, mail order, and specialty drug benefits. For drugs acquired through retail, the PBM

**\$74,618 in  
Pharmacy  
Claims  
Were Paid  
in Error**

contracts directly with the approximately 50,000 retail pharmacies located throughout the United States. For maintenance prescriptions that typically do not need to be filled immediately, the PBM offers the option of utilizing mail order

pharmacies. The PBM also provides specialty pharmacy services for members with rare and/or chronic medical conditions. PBMs are used to develop, allocate, and control costs related to the pharmacy claims program.

The contract outlines transparency standards that require PBMs to provide pass-through pricing based on its cost. Our responsibility is to review the performance of Caremark to determine if NALC charged costs to the FEHBP and provided services to its members in accordance with the OPM contract, the agreement between NALC and Caremark, and applicable Federal regulations.

Our audit consisted of a review of administrative fees, claim payments, fraud and abuse reporting, performance guarantees, and pharmacy rebates related to the FEHBP for contract years 2012 through 2014.

We determined that NALC and/or Caremark needs to strengthen its procedures and controls related to administrative fees, claim payments, fraud and abuse reporting, and performance guarantees. Specifically, our audit identified the following deficiencies that require corrective action:

- The Plan paid claims totaling \$54,766 for drugs that were not covered.
- The Plan paid \$19,852 in claims for dependents who were not eligible for coverage at the date the prescription was filled due to their age.
- The Plan inappropriately included non-FEHBP costs in its drawdowns related to the reimbursement of pharmacy costs. Additionally, the OIG was inadvertently provided with pharmacy claims data containing personal health information and other personally identifiable information related to Plan staff members.
- Caremark was unable to provide supporting documentation for all administrative fees charged to the Plan.
- The Plan did not report all cases of suspected fraud, waste, and abuse to the OIG.
- Caremark did not submit its annual performance reports or pay associated penalties to the Plan in a timely manner.



# Enforcement Activities

## Investigative Cases

*The Office of Personnel Management administers benefits from its trust funds, with over \$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 \$140 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 conducted by OPM's National Background Investigations Bureau (NBIB).*

During the reporting period, our office opened 53 investigations and closed 58, with 263 still in progress. Our investigations led to 24 arrests, 56 indictments and informations, 20 convictions and \$7,804,376 in monetary recoveries to OPM-administered trust funds. Our investigations, many of which we worked jointly with other Federal law enforcement agencies, also resulted in \$260,127,226 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 31.

### 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. In our experience, 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.

Our special agents are in regular contact with FEHBP health insurance carriers to identify possible fraud by health care providers and enrollees. Additionally, OIG 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 Manufacturer Agrees to Pay \$46.5 Million to Settle Allegations of Off-Market Labeling and False Claims

In September 2017, Novo Nordisk agreed to pay \$46.5 million to resolve allegations that it failed to comply with the Food and Drug Administration (FDA)-mandated Risk Evaluation and Mitigation Strategy (REMS) for its Type II diabetes medication Victoza from 2010 to 2014.

In order for the FDA to approve Victoza, an injectable drug used to improve glycemic control in adults with Type II diabetes, a REMS Communication Plan was required to mitigate the potential risk in humans of a rare form of cancer called Medullary Thyroid Carcinoma (MTC) associated with the drug. The REMS required Novo Nordisk to provide information regarding Victoza's potential risk of MTC to physicians. A manufacturer that fails to comply with the requirements of the REMS, including communicating accurate risk information, renders the drug misbranded under the law.

Our investigation uncovered that some Nova Nordisk sales representatives gave information to physicians that created the false or misleading impression that the Victoza REMS-required message was erroneous, irrelevant, or unimportant. This led some physicians to be unaware of the potential risks associated with prescribing Victoza. Nova Nordisk sales representatives also knowingly promoted the sale and use of Victoza to adult patients who did not have Type II diabetes. The FDA has not approved Victoza for use by adult patients who do not have Type II diabetes.

Of the total settlement amount, OPM will receive \$4,859,360 for losses to the FEHBP. The OPM OIG was notified of this case in June 2011 by DOJ via a *qui tam* lawsuit filed under the False Claims Act.

*A qui tam lawsuit may be filed on behalf of the Federal government if an individual has knowledge of a person or company filing false claims. The government may intercede or allow the plaintiff or relator to prosecute the lawsuit on its behalf. If the qui tam lawsuit is successful the relator receives a reward of 15-25 percent of the recovery if the government interceded; or 25-30 percent if the government did not intercede.*

### Virginia Hospital Group Agrees to Pay \$4.2 Million to Settle Civil Fraud Case

A *qui tam* lawsuit was filed in the U.S. District Court for the Eastern District of Virginia in 2014 alleging that Fredericksburg Hospitalist Group was knowingly and intentionally up-coding evaluation and management codes to their highest code levels in order to maximize their reimbursement rates. As a result of our joint investigation with the Department of Health and Human Services (HHS) OIG and the Department of Defense (DoD) OIG, the defendants were ordered to pay \$4,225,000 in damages to the United States and the Commonwealth of Virginia. Through this order, the FEHBP recovered \$424,728.



## Virginia Oncologist Agrees to Settlement to Repay FEHBP for Using Foreign Non-FDA Approved Drugs and Devices

After receiving a referral in January 2015 from the FDA's Office of Criminal Investigations (FDA OCI), we initiated an investigation, jointly with FDA OCI and DoD OIG, into an oncologist who was allegedly purchasing and using foreign, non-FDA approved drugs and devices to treat his cancer patients. The drugs were allegedly purchased from a foreign pharmaceutical company which was prosecuted for selling unapproved imported pharmaceuticals (cosmetic and oncology drugs) to its U.S. clients. Our investigation affirmed that the doctor did utilize some of the drugs alleged to be foreign, non-FDA approved drugs.

The case was declined for criminal prosecution, but was accepted for civil settlement negotiations by the U.S. District Court for the Eastern District of Virginia. In May 2017, the doctor was ordered to pay \$36,770, of which the FEHBP received \$12,477.

## Virginia Podiatrist Agrees to Settlement for CPT Upcoding

In 2014, Aetna, a FEHBP contract carrier, notified us of a podiatrist they believed was billing for services under an incorrect (higher-paying) Current Procedural Terminology (CPT) code. Through patient interviews, we determined that the podiatrist was treating Morton's neuroma (a condition that affects the nerves of the foot, typically between the interior metatarsals) with injections consisting of alcohol or cortisone which are reimbursable under CPT codes 64455 or 64632. However, the physician was billing the FEHBP for other peripheral nerve destruction under CPT code 64640, which includes injection of a chemical neurolytic agent or use of thermal, electrical, or radiofrequency techniques. Providers may also bill for additional services, such as the administration of intravenous fluids or the use of durable medical equipment, when using CPT code 64640.

The case was declined for criminal prosecution, but was accepted for civil litigation in the U.S. District Court for the Eastern District of Virginia. Due to financial means available to the defendant, the Government executed a settlement agreement with the podiatrist in May 2017, recovering \$21,430 for the FEHBP.

## Qualitest Pharmaceuticals Agree to Pay \$22 Million to Resolve Allegations that it Sold Understrength Fluoride Tablets

A \$22.44 million settlement was reached with Vintage Pharmaceuticals, LLC, doing business as Qualitest Pharmaceuticals; Vintage's corporate parent Endo Pharmaceuticals, Inc.; and seven of their corporate subsidiaries or affiliates (collectively, "Qualitest") as a result of a civil fraud lawsuit. Qualitest allegedly violated the False Claims Act by knowingly manufacturing and selling understrength chewable fluoride tablets that were prescribed to children living in communities without fluoridated water supply to prevent tooth decay, resulting in Medicaid and the FEHBP paying millions of dollars for the understrength tablets.

As part of the settlement, Qualitest admitted that the drug labeling for their chewable fluoride tablets stated that those tablets contained 1.0 mg, 0.5 mg, and 0.25 mg of fluoride and the drug labeling specifically referenced the guidelines from the American Dental Association and the American Academy of Pediatrics. Qualitest admitted, instead of using the amount of sodium fluoride that would result in the tablets containing the correct amount of fluoride ion, Qualitest used less than half the appropriate amount of sodium fluoride. Qualitest further admitted, this caused children taking the Qualitest fluoride tablets to receive less than half the amount of fluoride ion recommended by the American Dental Association and American Academy of Pediatrics guidelines.

As a result of the settlement, the FEHBP will receive \$682,761. This was a joint investigation by the Federal Bureau of Investigation (FBI), the HHS OIG, the FDA and our office.



## Michigan Allergy Group Settles Allegations of Double Billing

In September 2015, we received a civil *qui tam* complaint alleging that a Michigan based allergist group practice was double billing Federal health care programs for an unspecified number of vials of Xolair, a prescription asthma medication. Xolair is sold in single-use vials, and many patients receive doses of the drug that require health care providers to administer a partial vial of the drug. In situations where a patient's dose resulted in a leftover partial vial of Xolair, the physician group billed Federal health care programs for the entire single use vial, but then administered the leftover amount to a second patient, and billed the health care programs a second time for administering that amount.

In June 2017, the physician group signed a settlement agreement to pay \$417,675 in restitution and penalties to Federal health care programs. As a result of the agreement, the FEHBP received \$2,102.

## Florida Parathyroid Surgeon Agrees to Pay \$4 Million Settlement for Allegations of Violating the False Claims Act

In July 2017, a Florida parathyroid surgeon and his surgical center agreed to pay the U.S. Government \$4 million to settle a False Claims Act lawsuit alleging he defrauded Federal health care programs through various unlawful billing practices. It was alleged that the surgeon and his practice falsely billed the Government for pre-operative examinations performed on the day before or the day of surgery.

The surgeon and his practice were also accused of engaging in duplicative billing practices. Allegedly, they charged and collected extra fees for services from Federal health care beneficiaries when they had already received payment for those services from the Government. These extra fees ranged from \$150 to \$750 for Florida residents, to \$1,750 or more for patients who lived out-of-state. The

alleged billing schemes took place over several years, beginning in April 2008 and ending in late December 2016. As a result of the settlement, the FEHBP will receive \$111,906.

Our office worked this case with the HHS OIG and the DoD OIG.

## Pharmaceutical Company Agrees to Pay Over \$7.55 Million to Resolve Allegations it Paid Kickbacks to Physicians

In September 2017, Galena Biopharma, Inc. (Galena) agreed to pay more than \$7.55 million to resolve allegations that it paid kickbacks to doctors to induce them to prescribe its fentanyl-based drug, Abstral. The allegations arose from a *qui tam* suit filed under the False Claims Act.

Galena allegedly paid multiple types of kickbacks to induce doctors to prescribe Abstral, including providing more than 85 free meals to doctors and staff from a single, high-prescribing practice; paying physicians up to \$6,000 in speaking fees to attend an "advisory board" that was attended by Galena sales team members; and paying approximately \$92,000 to a physician-owned pharmacy under a performance-based rebate agreement to induce the owners to prescribe Abstral. Galena also allegedly paid physicians to refer patients to the company's RELIEF patient registry study, which was supposedly designed to collect data on patient experiences with Abstral, but acted as a means to induce the doctors to prescribe Abstral.

Galena sold Abstral in November 2015 after booking net losses on Abstral in each year that it owned the drug, beginning in June 2013. During that period, Medicare, TRICARE, and the FEHBP paid \$13.6 million for Abstral prescriptions.

As a result of the settlement, the FEHBP will receive \$52,199. This case was worked jointly with the HHS OIG, the DoD OIG and our office.



## Co-owners of a California Pharmacy and Medical Clinic Conspire to Defraud Various Health Care Benefit Programs

This investigation was opened in August 2009, pursuant to a referral from Caremark and leads developed through our law enforcement partners working the Health Care Fraud Prevention and Enforcement Action Team (HEAT) Strike Force. The lengthy investigation determined that the office manager/part-owner of a Reseda, California medical clinic and the lead pharmacist/co-owner of a southern California pharmacy participated in a health care fraud scheme that billed private insurance plans for prescription medications that were never dispensed. The co-owner of the medical clinic created fictitious prescriptions purportedly for patients of the medical clinic who were insured by health care benefit programs. Those prescriptions were then provided to the pharmacist who submitted false and fraudulent bills for prescription drugs that had not been dispensed to the patients. As a result, the pharmacy received substantial payments from various health care benefit programs to which it was not entitled. The pharmacist paid kickbacks to the co-owner of the medical clinic exceeding \$1.1 million.

In March 2017, the co-owner of the medical clinic was convicted and sentenced to 51 months in Federal prison for his role in the fraud scheme. He was also ordered to pay nearly \$950,000 in back taxes to the Internal Revenue Service (IRS). In May 2017, the pharmacist was sentenced to 30 months in Federal prison.

Both defendants were ordered to pay joint restitution of \$1,901,780 to all victims. The FEHBP received \$348,158 in restitution.

The case was investigated jointly by the FBI, the IRS and the OPM OIG.

## Pulmonary Services Company Agrees to Pay \$11.4 Million Settlement for Allegations of Violating the False Claims Act

Braden Partners, L.P., doing business as Pacific Pulmonary Services, entered into a settlement agreement with the Government to pay \$11.4 million to resolve allegations against it and its general partner, Teijin Pharma USA LLC, for violating the False Claims Act. The California-based company furnishes stationary and portable oxygen tanks and related supplies and sleep therapy equipment, to patients' homes in California and other states.

The Government alleges that, beginning in about 2004, Pacific Pulmonary Services began submitting claims to Medicare, TRICARE and the FEHBP for home oxygen and oxygen equipment without obtaining a physician authorization, as required by Medicare program rules. Further, beginning in 2006, company patient care coordinators allegedly agreed to make patient referrals to sleep testing clinics in exchange for those clinics' agreement to refer patients to Pacific Pulmonary Services for sleep therapy equipment.

The FEHBP received \$87,574 in restitution. This amount was limited by the terms of the settlement and the United States Attorney's Office to only Medicare crossover claims paid by the FEHBP. HHS OIG was the lead agency on the investigation.

## Postal Employee Pleads Guilty to Felony Theft

Group Health Cooperative, an FEHBP contract carrier, informed us of an FEHBP member who allegedly placed her live-in boyfriend on her FEHBP medical insurance policy, claiming that he was her husband. The defendant, who worked for the United States Postal Service (USPS), stated during an interview that she thought she was common law married since she lived with and had children with this individual. She stated that they were not married but she has been covering the individual under her FEHBP policy since 2004.



In December 2016, the USPS employee pled guilty and was sentenced in Lewis County, Washington for felony theft. She was sentenced to 90 days electronic home monitoring. In April 2017, a restitution order was entered to pay OPM \$351,496 for FEHBP benefits paid to an ineligible member.

This case was investigated by the USPS OIG, the Washington Department of Insurance and the OPM OIG.

## 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 U.S. 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

### Annuitant Agrees to Repay OPM After Improperly Receiving Dual FERS and FECA Benefits

In July 2016, OPM OIG received notification from the Department of Labor (DOL) OIG that a FERS annuitant was improperly receiving FERS benefits while also receiving Federal Employees' Compensation Act (FECA) benefits from the DOL Office of Workers' Compensation Programs (OWCP). In April 2013, the FERS annuitant

elects to receive FECA benefits instead of FERS benefits; however, OPM erroneously initiated FERS benefit payments to the annuitant. The OPM program office calculated the overpayment amount of \$107,864 for payments made to the annuitant from May 2013 through August 2016. In August 2017, OPM submitted a debt referral to OWCP to immediately begin collecting the amount owed by the annuitant.

### Remarried Survivor Annuitant Guilty of Fraud

We received an anonymous letter in 2013 stating that a survivor annuitant had re-married and continued to collect survivor benefits on behalf of her deceased husband. Under CSRS, a survivor annuity to a widow or widower starts (1) the day after the annuitant's death, or (2) the day after the entitlement of any former spouse ends if that entitlement had prevented the widow(er) from receiving the survivor annuity. It continues to the end of the month before the one in which he or she remarries before age 55 or dies. If the widow(er) does not remarry before age 55 or was married to the annuitant for at least 30 years, the annuity continues for life.

The investigation found that the survivor had re-married three times. She was interviewed by OPM OIG agents on two occasions and denied any marriages other than her marriage to the annuitant.

The survivor annuitant married her second husband in March 1999, in Las Vegas, Nevada. She used a variant of her name and a different date of birth when she applied for her marriage license. She was 44 years old at the time of the marriage.

The survivor annuitant married her third husband in January 2003, in Las Vegas at the age of 48. At the age of 49, she married her fourth husband in February 2004 in Las Vegas.

The survivor was indicted in the Central District of California in March 2016, and was charged with wire fraud, theft of Government money and false statements. In January 2017, she pled guilty to theft of Government money. In April 2017, she was sentenced to 12 months home confinement, 36 months' probation, and to pay \$246,240 in restitution to OPM.



## Survivor Annuitant's Grandson Pleads Guilty to Stealing Annuity Payments

In December 2014, we received a fraud referral from OPM's Retirement Inspections Group regarding a deceased survivor annuity and the fraudulent diversion of annuity payments. The survivor annuitant died in February 2004; however, the death was not reported to OPM and OPM continued to directly deposit monthly annuity payments into the deceased survivor annuitant's checking account through December 2012, resulting in an overpayment of \$126,852.

Our investigation determined that the deceased survivor annuitant's grandson was the person responsible for fraudulently obtaining survivor annuity payments during this period. The grandson assisted his grandmother in handling her affairs and was made her Power of Attorney to assist in the sale of her home since she was moving to a nursing home. After the survivor annuitant's death, the grandson changed the mailing address to his current address. This address was automatically updated with OPM's records through an automated file update provided by the USPS. This address remained the current address on file until OPM received notification of her death.

During an interview with OPM OIG special agents, the grandson denied having knowledge of his grandmother's checking account after her death and stated his mother closed the accounts. When confronted with evidence obtained through bank records, the subject provided a voluntary statement and confessed to writing checks from the account, reordering new checks, and lying to the interviewing agents regarding previous statements made.

In January 2017, the grandson pled guilty to theft of public money. In April 2017, he was sentenced to 6 months of house arrest, followed by 36 months of probation, and ordered to pay OPM restitution of \$112,249.

## National Guardsman Defrauds Various Government Programs by Lying About Injuries Suffered in Iraq

In 2014, a joint investigation with the Social Security Administration (SSA) OIG revealed that a beneficiary made false statements in order to receive disability related payments from various Federal and state

agencies, including OPM. The disability relates to the beneficiary's assertion that he was wounded during his tour of duty with the Idaho National Guard while in Iraq in 2005 where he alleges he sustained physical injuries during a rocket attack. In addition, he used this false information to obtain an Army-issued Combat Action Badge and a Purple Heart medal.

The beneficiary pled guilty to wire fraud, in the Western District of Washington. He was sentenced in June 2017 to three years in prison, followed by three years supervised release. He was also ordered to pay \$646,301 in restitution to the Veterans Administration (VA), Social Security disability program, VA Caregiver program, Department of Education's Loan Forgiveness Program, Washington State Employment and OPM for losses sustained as a direct result of his false assertions of disabilities or inability to work. The OPM loss totaled \$48,226. The Department of the Army officially and permanently revoked both the Combat Action Badge as well as the Purple Heart that were issued to the beneficiary.

## Deceased OPM Annuitants Victims of Identity Theft

In November 2013, the OPM OIG received an inquiry from the SSA OIG regarding two annuitants whose bank accounts were allegedly compromised by Chase Bank employees involved in fraudulent activity.

Four Chase Bank employees stole money from accounts that they identified as dormant. Two of the fifteen bank accounts that were affected belonged to deceased OPM annuitants.

In December 2015, a felony indictment was filed and an arrest warrant was issued for all four of the bank employees involved in the fraud, in the Supreme Court of the State of New York, Kings County. The charges included conspiracy, grand larceny, and falsifying business records.

In May 2017, the first bank employee was acquitted in trial. In August 2017, the second bank employee was sentenced to 60 months' probation and ordered to pay restitution of \$100,000 to Chase Bank. In September 2017, the third bank employee received a sentence of conditional discharge and 50 hours of community service. The remaining bank employee has been a fugitive since the indictment and cannot be located.



## REVOLVING FUND PROGRAM INVESTIGATIONS

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

Prior to the establishment of the National Background Investigations Bureau (NBIB) effective October 1, 2016, OPM's Federal Investigative Services (FIS) conducted background investigations on Federal job applicants, employees, military members, and contractor personnel for suitability and security purposes. FIS conducted 95 percent of all personnel background investigations for the Federal Government. With a staff of over 8,800 Federal and contract employees, FIS processed over 2.6 million background investigations in FY 2016. 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 will continue to provide this necessary investigative oversight for the NBIB. 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.

No Revolving Fund investigations were closed during the reporting period.

## INTERNAL AND ADMINISTRATIVE INVESTIGATIONS

In addition to conducting criminal and civil investigations, our office also conducts administrative investigations of fraud, waste, abuse or mismanagement at OPM. The following represents our activities during the reporting period.

### The OIG Receives Repayment from Former OPM Contractor who Falsified Time and Attendance Reports

In the prior Semiannual Report for the period ending March 31, 2017, we reported on a former OPM contract Systems Administrator that was hired to implement system enhancements on a joint project for the OIG and OPM's Planning and Policy Analysis (PPA) Program Management Office. The contractor worked at both OPM and the National Security Agency (NSA), but neither agency was aware of the other. He submitted falsified time sheets to both agencies for time he did not work, resulting in overpayments of \$43,706 from OPM and \$26,940 from NSA. The case summarized below was inadvertently not reported during the last Semiannual Report period and is associated with this case.

In March 2012, a contract employee was hired to work at OPM as a contract Systems Administrator for the PPA Program Management Office, and the OIG. The contract employee was specifically hired to implement system enhancements on the joint OIG Data Warehouse project.

In late July 2012, the OPM contract employee's fraudulent scheme was discovered by OIG and PPA management after they met to discuss cost settlements prior to the end of the 2012 FY, since the costs were split between OIG and PPA respectively. Based on observations by OIG management that the contract employee was not present in the office on a consistent basis, his time card was examined to ensure that he was not billing for hours he had not worked. OPM OIG agents also obtained the OPM building badging access report to compare to the time card. We found that the contract employee overbilled OPM 380.5 hours from March 2012 to September 2012 for a loss of more than \$66,000. The contractor stated that some of the hours he charged for were for work he performed remotely. However, the Data Warehouse



project did not allow work to be performed outside of the OIG office.

In June 2013, the U.S. Attorney's Office in the District of Columbia declined the case for criminal prosecution. In January 2015, OPM received a \$66,201 reimbursement payment from the contract employee's employer, in order to settle the issue concerning the falsified time and attendance reports. A notice of proposed debarment was issued to the contract employee. The proposed debarment is for a period of three years.

## OIG HOTLINE AND COMPLAINT ACTIVITY

The OIG's Fraud Hotline also contributes to identifying fraud and abuse. The Hotline telephone number and mailing address are listed on our OIG Web site at <https://www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse>, along with an online complaint form that allows the complainant to remain anonymous. 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 886 hotline inquiries during the reporting period, with 162 pertaining to health care and insurance issues, 215 concerning retirement, 50 related to Revolving Fund programs, and the remainder fell into other categories. The table on page 31 reports the summary of hotline activities including telephone calls, emails, and letters.

### 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 opened 106 complaints. Of those complaints, 54 related to health care fraud, 31 involved retirement fraud, 14 pertained to OPM's Revolving Fund programs, and the remainder fell into other categories. 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 suspension and debarment program, which is separate from the OIG's Administrative Sanctions Program of FEHBP health care providers. The OPM 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 3 cases to the agency for debarment action, for a total of 110 referrals since the inception of the program. OPM issued debarment letters to seven individuals between April 1, 2017 and September 30, 2017. The OIG also referred one case to the agency for suspension action. OPM issued suspension letters to three individuals during this reporting period.

The majority of cases we have referred for debarment action were former FIS employees and contractors. Most of these former FIS employees and contractors were referred to us through FIS's 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.

During this reporting period, the Office of Investigations also referred 42 cases involving health care providers to the OIG's Administrative Sanctions Group for potential suspension or debarment from the FEHBP.



## 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 34,941 active suspensions and debarments from the FEHBP.*

During the reporting period, our office issued 475 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 2,541 sanctions-related inquiries.

**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.*

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 cases, 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.

### Kentucky Physician and Practice Debarred After Revocation of Medical License

In September 2016, our office debarred a Kentucky physician based on the Commonwealth of Kentucky Board of Medical Licensure's (Board) decision to revoke the physician's medical license. In 2016, the Board issued a suspension order after the U. S. District Court for the Eastern District of Kentucky indicted him in October 2014, for health care fraud and conspiracy to pay or receive health care kickbacks.

The physician was an emergency medicine specialist, and the owner of a health care facility in the state of Kentucky. He was indicted as part of a criminal conspiracy that included his wife and several employees that participated in fraud schemes that billed Medicare and Medicaid more than \$15 million in false billings. Patients were billed for equipment that was not provided; and for care and services that were not rendered. The charges followed an investigation conducted by the FBI and the Kentucky State Police.

The physician provided prescriptions for controlled substances to individuals who were either selling the drugs and/or to individuals who were abusing the drugs. He required all of his patients to undergo monthly urine drug screening to test for the presence of the drugs he prescribed, as well as other illegal narcotics. The physician instructed his staff to falsify medical records to hide the test results when they showed that the patients were not taking the prescribed pills or evidence of illegal drug use existed.



Federal regulations state that OPM may debar providers of health care services from participating in the FEHBP whose license to provide a health care service has been revoked, suspended, restricted, or not renewed, by a State licensing authority for reasons relating to the provider's professional competence, professional performance or financial integrity. In addition, based on ownership and control, we debarred the physician's medical clinic which was used in committing the fraudulent activities.

Our debarment of the physician and his medical clinic is for an indefinite period of time pending full reinstatement of physician's medical license. This case was referred to us by our investigators.

### Virginia Physician Debarred After Conspiracy Conviction

In September of 2017, we debarred a Virginia physician based on a conviction by the Circuit Court of the County of Chesterfield, Virginia. In March 2017, the physician entered into an Alford plea, in which the defendant does not admit guilt, but acknowledges that prosecutors have enough evidence for a conviction.

In the plea agreement, the physician pled guilty to engaging in a criminal conspiracy with six others from December 2013 to May 2015. According to authorities, he recruited a co-defendant, to fill the prescriptions, and in turn, the co-defendant enlisted four others to participate in the scheme. With the intent to evade the law he engaged in the following:

- Wrote fraudulent prescriptions for Oxycodone for individuals outside of a bona-fide practitioner-patient relationship as part of an unlawful scheme to illegally obtain sell and/or distribute controlled substances.
- Wrote fraudulent prescriptions for Oxycodone to individuals in exchange for payment of \$50 per prescription.
- Wrote a prescription for Percocet using the name, date of birth, and other personal information of an individual without that person's permission or knowledge.
- Obtained personal information from individuals to establish phony patient records and falsified information within those records.

The physician was convicted and sentenced to a 10-year probation period for Conspiracy to Violate the Control Drug Act.

In addition, the Virginia Board of Medicine suspended his license for violating certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia.

We debarred the physician for a period of 10 years based upon the aggravating factors associated with his offense including risk to patient health and safety associated with his creation of fraudulent prescriptions; the prolonged period during which he knowingly submitted false claims and enlisted others to participate in this criminal conspiracy; and financial loss to a FEHBP carrier.

### New Mexico Physician Debarred for Negligence

In September of 2017, we debarred a New Mexico physician who described himself as a "holistic" cardiologist. The physician was the owner of a clinic that operated out of his home in Santa Fe, New Mexico. The physician's license was suspended in November 2016, by the New Mexico Medical Board (Board) for violating provisions of the Medical Practice Act.

In June 2015, the United States District Court for the District of New Mexico indicted him for health care and wire fraud. The indictment alleged that he executed a scheme to defraud Medicare and other health care benefits programs between January 2010, and May 2011, by submitting fraudulent claims. According to the indictment, he executed his fraudulent scheme by:

- Performing and billing for a wide array of unnecessary tests on every new patient and submitting false diagnoses with the billing claims to justify the tests to the insurance plans;
- Inserting false symptoms, observations, and diagnoses into patients' medical charts to provide written support for the tests he ordered or performed;
- Inserting photocopied clinical notes, diagnostic test results, and ultrasound images in patients' medical charts to create a written record of procedures that were either not performed or that had not been sufficiently documented to support the billing;



- Submitting the photocopied notes, results, and images to the insurance plans when the plans requested documentation to support the claims submitted;
- Submitting claims to health plans for procedures that were never performed;
- Submitting claims for procedures performed on two consecutive dates to increase the amount paid for services that were actually rendered together on one single date; and,
- Misusing billing codes and modifiers in order to increase his rate of reimbursement.

In February 2017, he pled guilty to one count of the indictment, and agreed to pay restitution. The physician is still awaiting sentencing. We debarred the physician based on the New Mexico Medical Board's suspension of his medical license for an indefinite period pending the resolution of his medical licensure and the Court's adjudication.

### **Pennsylvania Physician Debarred After Conviction for Health Care Fraud**

Our office debarred a Pennsylvania physician in September 2017, after his February 2017, sentencing by the United States District Court for the Eastern District of Pennsylvania for health care fraud. Our Office of Investigations referred this case to the OIG's Administrative Sanctions staff. The physician was charged by criminal information in August 2016, after he pled guilty

to a scheme that defrauded \$5 million from Medicare, Medicaid and private insurance companies.

According to the information, the physician admitted that between January 2008 and October 2014 that he submitted fraudulent claims to Medicare, Medicaid and four private insurance companies for podiatric services and procedures that were not provided. He subjected his patients to unnecessary injections, debridement (removal of dead, infected or foreign material to promote wound healing) and nail avulsions (removal of the entire or partial nail plate).

In addition, he admitted to submitting fraudulent claims for medically unnecessary procedures and services that were not reimbursable by Medicare or the other insurance carriers. In some cases, he provided "pill seeking" patients with prescriptions for Oxycodone in exchange for payments from health insurance providers. Individuals seeking Oxycodone from him received injections in their toes and feet, for which the physician submitted fraudulent claims to the patients' insurance providers. He administered these medically unnecessary injections to create the appearance of legitimacy for his prescriptions of opioids.

The physician was sentenced to eight years in prison, three years supervised release; and ordered to pay \$5 million in restitution. Our debarment of this physician is for a period of 11 years to coincide with his incarceration and supervised release.



# Evaluation Activities

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

The following evaluation reports were issued during the reporting period.

## **OPM's Insider Threat Program**

WASHINGTON, D.C.

**Report No. 4K-CI-00-16-053**

APRIL 7, 2017

The objectives of this evaluation were to determine if OPM's Insider Threat Program is in compliance with the *National Insider Threat Policy and Minimum Standards* and assess the progress of the program's implementation.

OPM established its Insider Threat Program in May 2013, in accordance with Executive Order (E.O.) 13587, *Structural*

*Reforms to Improve the Security of Classified Networks and the Responsible Sharing and Safeguarding of Classified Information*, and in conjunction with the White House Memorandum of November 21, 2012, *National Insider Threat Policy and Minimum Standards for Executive Branch Insider Threat Programs*, which states that all executive branch departments and agencies that have access to classified information should implement an insider threat detection and prevention program.

To ensure agencies' program implementation reflected the requirements of these legal authorities, the National Insider Threat Task Force developed a *Guide to Accompany the National Insider Threat Policy and Minimum Standards* in November 2013, which outlined ten standards that should be followed in the insider threat policy and implementation plan.

We determined that OPM's Insider Threat Program was in compliance with the policies and standards of the *National Insider Threat Policy and Minimum Standards*. However, we identified areas within the program where corrective action was needed. Specifically, we found the following:

- OPM did not follow recommendations by the National Insider Threat Task Force's 2016 post-assessment;
- OPM's Office of Security Services (Security Services) did not have a process in place for insider threat personnel to verify that all cleared employees are meeting the training requirements;
- Security Services did not have a process in place to ensure that cleared employees submit their *Employee Foreign Travel Questionnaire* in a timely manner upon their return from foreign travel; and,
- OPM's senior official's performance standards did not reflect their role and responsibility as it related to the Insider Threat Program.

The OPM has addressed all the recommendations in this evaluation and we consider it closed.

## OPM's Conference Spending Reporting

WASHINGTON, D.C.

Report No. 4K-CF-00-17-015

JUNE 22, 2017

The objective of this evaluation was to determine if OPM had policies and procedures for reporting its conference spending in accordance with the Office of Management and Budget (OMB) and the *Consolidated Appropriations Act* requirements.

*Executive Order 13589* directed all agencies to reduce overall expenses within their support operations by not less than 20 percent starting in fiscal year 2013. In May 2012, the Office of Management and Budget (OMB)

issued Memorandum M-12-12, *Promoting Efficient Spending to Support Agency Operations*, outlined the steps agencies could take to improve operations, increase efficiency, and cut unnecessary spending to include conference expenses. The specific requirements for agencies included:

- Initiating a senior level review for all planned conferences,
- Initiating a senior level approval for all future conference net expenses in excess of \$100,000,
- Prohibiting net expenses in excess of \$500,000 on a single conference; and,
- Initiating public reporting for all conferences where net expenses are in excess of \$100,000.

We determined that OPM does not have formalized policies and procedures for reporting its conference spending in accordance with OMB and the *Consolidated Appropriations Act* requirements. Specifically, we identified the following issues related to OPM's process for reporting its conference spending:

- Unclear distinction between what is considered a "conference" versus training;
- Undefined roles and responsibilities for conference reporting;
- Agency officials did not know the reporting requirements for net conference expenses (all direct and indirect conference costs paid by the agency minus any revenue collected from the conference) to include the Consolidated Appropriations Act requirements;
- No designated official for approving agency-hosted conferences; and,
- No responsible official designated to develop policies and procedures for reporting conference.

The OPM has not addressed the recommendations to this report.



# Legal and Legislative Activities

*Under the Inspector General Act of 1978, as amended, each statutory Inspector General has the right to obtain his or her own independent legal counsel in order to preserve the independence of the office and avoid possible conflicts of interest in conducting IG audits and investigations. Not only does the Office of Legal Affairs advise the Inspector General and other OIG offices on legal and regulatory matters, but it also works to develop and promote legislative proposals to prevent and reduce fraud, waste, and abuse in OPM programs.*

The Inspector General Act of 1978 (IG Act), as amended by the Inspector General Empowerment Act of 2016, requires that each OIG's Semiannual Report to Congress include a description of any attempts by the establishment to interfere with OIG independence, including incidents where the establishment resisted or objected to OIG oversight or restricted or significantly delayed access to information.

The OIG faced multiple attempts to restrict its access to information that were rectified with the attention of agency leadership. Specifically, OIG employees repeatedly encountered situations where OPM employees insisted that OIG requests for information or interviews be sent to a supervisor, either instead of or in addition to the individual employees from whom the information was sought. Although this response was espoused by employees in multiple OPM components, it was most commonly encountered during interactions with OPM's Human Resources (HR) office. The chief justification asserted for this stance was to ensure administrative efficiency in responding to OIG requests.

An attempt to impose such a requirement on the OIG is problematic for a number of reasons. First, sometimes OIG requests are sensitive and should not be shared beyond those individuals that the OIG has identified. Second, it is inappropriate for the agency to attempt to dictate how OIG oversight activities, particularly investigations, are conducted. Third, contrary to the stated goal of seeking administrative efficiency, it leads to delays that could run afoul of the timely access provisions of the IG Act. Finally, it raises concerns regarding the Whistleblower Protection Enhancement Act's "anti-gag" rule, which was crafted in part to ensure that employees have unfettered access to the OIG, as well as the statutory prohibitions against punishing employees who cooperate with or disclose information to the OIG.

OIG officials held meetings with the Acting Director, the General Counsel, and the Associate Director for HR to discuss the issue. All officials expressed a commitment to address the problem and the individual instances of restriction were resolved. However, as of the date of publication OPM has not issued agency-wide guidance to ensure that similar instances will not arise in the future.





# Statistical Summary of Enforcement Activities

## Judicial Actions and Recoveries:

Indictments and Informations .....	56
Arrests .....	24
Convictions .....	20
Restitutions and Settlements .....	\$7,804,376
Fines, Penalties, Assessments, and Forfeitures .....	\$260,127,226 <sup>1</sup>

## OIG Executive Actions:

Investigative Reports Issued .....	40
■ Report of Investigation .....	40
■ Communication of Investigative Findings .....	0
Whistleblower Retaliation Allegations Confirmed .....	0
Subjects Presented for Prosecution .....	21
■ Federal Venue .....	21
■ State Venue .....	0
■ Local Venue .....	0

## Administrative Sanctions Activity:

NBIB Cases Referred to OPM for Debarments and Suspensions .....	4
NBIB Debarments and Suspensions Issued by OPM .....	10
Health Care Debarments and Suspensions Issued .....	475
Health Care Provider Debarment and Suspension Inquiries .....	2,541
Health Care Debarments and Suspensions in Effect at End of Reporting Period .....	34,941

<sup>1</sup>This 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.



## Hotline Complaints & Complaints Received from Other Sources

	Health Care	Retirement	Revolving Fund	Other	Total
Hotlines Opened	162	215	50	459	886
<i>Referred To:</i>					
■ OPM Program Offices	56	156	25	10	247
■ FEHBP Insurance Carriers or Providers	1	N/A	N/A	N/A	1
■ Other Federal or State Agencies	13	3	2	209	227
Informational Only	57	28	19	228	332
Complaint Opened	2	4	1	2	9
Issue Resolved	19	10	3	7	39
Hotlines Closed	148	210	50	456	855
Hotlines Open at End of Reporting Period	14	14	0	3	31
Complaints Received From Other Sources	54	31	14	7	106
Complaints Closed	89	17	14	8	128

## Investigative Leads

	Total
Investigative Leads Received	498
<i>Declined Due To:</i>	
■ Low FEHBP Exposure	128
■ Lack of OIG Resources	61
■ Does Not Meet Reporting Guidelines	29
■ Allegations Not Substantiated by Carrier	3
■ Not Healthcare Related	2
Informational Only	68
Issue Resolved - No Referral	5
Referred to Other Agencies	3
Inquiries Initiated	18
No Further Action - No Response From Special Investigations Unit	1
Investigative Leads Closed	318
Investigative Leads Open at the End of Reporting Period	180

*Note: The investigative statistics were determined and independently validated by running queries from our investigative tracking system to extract the investigative actions taken during the reporting period.*



# Appendices

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

APRIL 1, 2017 TO SEPTEMBER 30, 2017

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	5	\$40,028,787
B. Reports issued during the reporting period with findings	6	9,613,432
Subtotals (A+B)	11	49,642,219
C. Reports for which a management decision was made during the reporting period:	7	27,065,011
1. Disallowed costs	N/A	9,898,966
2. Costs not disallowed	N/A	17,166,045 <sup>2</sup>
D. Reports for which no management decision has been made by the end of the reporting period	4	22,577,208
E. Reports for which no management decision has been made within 6 months of issuance	2	22,497,998

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



**APPENDIX I-B**  
**Final Reports Issued With Questioned Costs**  
**for All Other Audit Entities**

APRIL 1, 2017 TO SEPTEMBER 30, 2017

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	3	\$183,865
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	3	183,865
C. Reports for which a management decision was made during the reporting period:		
1. Disallowed costs	N/A	13,599
2. Costs not disallowed	N/A	0
D. Reports for which no management decision has been made by the end of the reporting period	1	170,266
E. Reports for which no management decision has been made within 6 months of issuance	1	170,266



## APPENDIX II

### Resolution of Questioned Costs in Final Reports for Insurance Programs

APRIL 1, 2017 TO SEPTEMBER 30, 2017

Subject	Questioned Costs
A. Value of open recommendations at the beginning of the reporting period	\$139,887,494
B. Value of new audit recommendations issued during the reporting period	9,613,432
Subtotals (A+B)	149,500,926
C. Amounts recovered during the reporting period	15,120,067
D. Amounts allowed during the reporting period	45,202,931
E. Other adjustments	46,997 <sup>3</sup>
Subtotals (C+D+E)	60,369,995
F. Value of open recommendations at the end of the reporting period	89,130,931

<sup>3</sup>Includes a lost investment income addition and a carryover credit reduction.

## APPENDIX III

### Final Reports Issued With Recommendations for Better Use of Funds

APRIL 1, 2017 TO SEPTEMBER 30, 2017

Subject	Number of Reports	Dollar Value
A. Reports for which no management decision had been made by the beginning of the reporting period	1	\$108,880,417
B. Reports issued during the reporting period with findings	0	0
Subtotals (A+B)	1	108,880,417
C. Reports for which a management decision was made during the reporting period:	0	0
D. Reports for which no management decision has been made by the end of the reporting period	1	108,880,417
E. Reports for which no management decision has been made within 6 months of issuance	1	108,880,417



**APPENDIX IV**  
**Insurance Audit Reports Issued**  
 APRIL 1, 2017 TO SEPTEMBER 30, 2017

Report Number	Subject	Date Issued	Questioned Costs
1M-OF-00-16-058	Multi-State Plan Program Operations at Arkansas BlueCross BlueShield in Little Rock, Arkansas	April 14, 2017	\$ 0
1C-8W-00-16-041	UPMC Health Plan in Pittsburgh, Pennsylvania	May 3, 2017	0
1C-76-00-16-042	Union Health Service, Inc. in Chicago, Illinois	May 10, 2017	56,890
1A-10-18-16-009	Anthem Inc. in Mason, Ohio	May 30, 2017	3,024,520
1A-99-00-16-043	Global Duplicate Claim Payments for BlueCross and BlueShield Plans in Washington, D.C.	June 21, 2017	5,967,324
1A-10-60-16-056	BlueCross BlueShield of Rhode Island in Providence, Rhode Island	July 27, 2017	466,401
1B-47-00-17-003	American Postal Workers Union Health Plan in Glen Burnie, Maryland	July 27, 2017	0
1J-OE-00-17-036	Federal Employees Dental and Vision Insurance Program Premium Rate Proposal of GEHA Connection Dental Federal for 2018 in Lee's Summit, Missouri	September 9, 2017	0
1J-OK-00-17-037	Delta Dental's Federal Employees Dental Program's Premium Rate Proposal for 2018 in Rancho Cordova, California and San Francisco, California	August 15, 2017	0
1H-01-00-16-045	National Association of Letter Carriers Health Benefit Plan's Pharmacy Operations as Administered by CaremarkPCS Health, L.L.C. for Contract Years 2012 through 2014 in Scottsdale, Arizona	September 29, 2017	74,618
1B-44-00-17-002	Special Agents Mutual Benefit Association in Rockville, Maryland	September 29, 2017	23,679
1D-V3-00-17-005	HealthPartners in Minneapolis, Minnesota	September 29, 2017	0
1J-OB-00-16-063	Federal Employees Dental and Vision Insurance Program Operations as Administered by UnitedHealthcareInsurance Company for Contract Years 2014 and 2015 in Columbia, Maryland	September 29, 2017	0
<b>TOTALS</b>			<b>\$9,613,432</b>



**APPENDIX V**  
**Internal Audit Reports Issued**  
 APRIL 1, 2017 TO SEPTEMBER 30, 2017

Report Number	Subject	Date Issued
4A-CF-00-17-012	OPM's FY2016 Improper Payments Reporting in Washington, D.C.	May 11, 2017
4A-OO-00-16-046	OPM's Purchase Card Program in Washington, D.C.	July 7, 2017

**APPENDIX VI**  
**Information Systems Audit Reports Issued**  
 APRIL 1, 2017 TO SEPTEMBER 30, 2017

Report Number	Subject	Date Issued
IC-WD-00-16-059	Information Systems General and Application Controls at Dean Health Plan in Madison, Wisconsin	June 5, 2017
4A-CI-00-17-014	OPM's Security Assessment and Authorization Methodology in Washington, D.C.	June 20, 2017
1C-GA-00-17-010	Information Systems General and Application Controls at MVP Health Care in Schenectady, New York	June 30, 2017
4A-CF-00-17-043	Information Technology Security Controls of the OPM's Consolidated Business Information System in Washington, D.C.	September 29, 2017
4A-CF-00-17-030	Information Technology Security Controls of the OPM's SharePoint Implementation in Washington, D.C.	September 29, 2017
4A-CF-00-17-044	Information Technology Security Controls of the OPM's Federal Financial System in Washington, D.C.	September 29, 2017

**APPENDIX VII**  
**Evaluation Reports Issued**  
 APRIL 1, 2017 TO SEPTEMBER 30, 2017

Report Number	Subject	Date Issued
4K-CI-00-16-053	OPM's Insider Threat Program in Washington, D.C.	April 7, 2017
4K-CF-00-17-015	OPM's Conference Spending Reporting in Washington, D.C.	June 22, 2017



## APPENDIX VIII

### Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF SEPTEMBER 30, 2017

Report Number	Subject	Date Issued
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; 5 open recommendations	July 16, 2012
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
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



## APPENDIX VIII

### Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF SEPTEMBER 30, 2017

(Continued)

Report Number	Subject	Date Issued
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
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
4A-CI-00-14-015	Information Technology Security Controls of the OPM's Development Test Production General Support System FY 2014 in Washington, D.C.; 6 total recommendations; 5 open recommendations	June 6, 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; 15 open recommendations	November 12, 2014
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
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; 1 open recommendation	April 13, 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; 2 open recommendations	May 15, 2015
4A-HR-00-13-055	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; 1 open recommendation	June 17, 2015
1A-99-00-14-046	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 1 open recommendation	July 29, 2015
4A-RI-00-15-019	Information Technology Security Controls of 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; 2 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
4A-RI-00-16-014	Management Alert of Serious Concerns Related to OPM's Procurement Process for Benefit Programs in Washington, D.C.; 4 total recommendations; 2 open recommendations	October 14, 2015



## APPENDIX VIII

### Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF SEPTEMBER 30, 2017

*(Continued)*

Report Number	Subject	Date Issued
4A-CI-00-15-011	Federal Information Security Modernization Act for FY 2015 in Washington, D.C.; 27 total recommendations; 16 open recommendations	November 10, 2015
4A-CF-00-15-027	OPM's FY 2015 Consolidated Financial Statements in Washington, D.C.; 5 total recommendations; 5 open recommendations	November 13, 2015
1A-10-17-14-037	Health Care Service Corporation in Abilene, Texas; 16 total recommendations; 3 open recommendations	November 19, 2015
4K-RS-00-16-024	OIG's Special Review of OPM's Award of a Credit Monitoring and Identify Theft Services Contract to Winvale Group LLC, and its subcontractor, CSIdentity in Washington, D.C.; 2 total recommendations; 2 open recommendations	December 2, 2015
1A-99-00-15-008	Global Claims-to-Enrollment Match for BlueCross and BlueShield Plans in Washington, D.C.; 8 total recommendations; 5 open recommendations	January 21, 2016
4K-RS-00-15-050	OPM's Oversight of the Federal Workers' Compensation Program in Washington, D.C.; 5 total recommendations; 1 open recommendation	March 29, 2016
4A-CF-00-16-026	OPM's FY 2015 Improper Payments Reporting in Washington, D.C.; 6 total recommendations; 5 open recommendations	May 11, 2016
4A-CI-00-16-037	Second Interim Status Report on the OPM's Infrastructure Improvement Project - Major IT Business Case in Washington, D.C.; 2 total recommendations; 2 open recommendations	May 18, 2016
1A-99-00-15-047	Global Omnibus Budget Reconciliation Act of 1990 Claims for BlueCross and BlueShield Plans in Washington, D.C.; 5 total recommendations; 3 open recommendations	June 17, 2016
4A-CA-00-15-041	OPM's Office of Procurement Operations' Contract Management Process in Washington, D.C.; 6 total recommendations; 6 open recommendations	July 8, 2016
1C-L4-00-16-013	HMO Health Ohio in Cleveland, Ohio; 2 total recommendations; 2 open recommendations	September 23, 2016
4K-RS-00-16-023	OPM's Retirement Services' Customer Service Function in Washington, D.C.; 3 total recommendations; 3 open recommendations	September 28, 2016
1A-99-00-15-060	Global Coordination of Benefits for BlueCross and BlueShield Plans in Washington, D.C.; 3 total recommendations; 2 open recommendations	October 13, 2016
4A-CI-00-16-061	Web Application Security Review in Washington, D.C.; 4 total recommendations; 4 open recommendations	October 13, 2016
4A-CI-00-16-039	Federal Information Security Modernization Act of FY 2016 in Washington, D.C.; 26 total recommendations; 22 open recommendations	November 9, 2016
1A-10-33-15-009	BlueCross and BlueShield of North Carolina in Durham, North Carolina; 6 total recommendations; 6 open recommendations	November 10, 2016



## APPENDIX VIII

### Summary of Reports More Than Six Months Old Pending Corrective Action

AS OF SEPTEMBER 30, 2017

*(Continued)*

Report Number	Subject	Date Issued
4A-CF-00-16-030	OPM's FY 2016 Consolidated Financial Statements in Washington, D.C.; 22 total recommendations; 22 open recommendations	November 14, 2016
4A-RS-00-16-035	Information Technology Security Controls of OPM's Federal Annuity Claims Expert System in Washington, D.C.; 13 total recommendations; 11 open recommendations	November 21, 2016
3A-CF-00-16-036	The Combined Federal Campaign of the National Capital Area for the 2013 through 2015 Campaign Periods in Bethesda, Maryland; 2 total recommendations; 2 open recommendations	January 24, 2017
1C-JN-00-16-019	Aetna Open Access - Capitol Region in Blue Bell, Pennsylvania; 5 total recommendations; 2 open recommendation	January 31, 2017

Note: Visit <https://www.opm.gov/our-inspector-general/> for the report of outstanding unimplemented recommendations.



## APPENDIX IX

### Most Recent Peer Review Results

AS OF SEPTEMBER 30, 2017

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

Subject	Date of Report	Result
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 <sup>4</sup>
System Review Report on 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 <sup>4</sup>
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 <sup>5</sup>
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>	December 2, 2016	Compliant <sup>5</sup>

<sup>4</sup>A peer review rating of **Pass** is issued when the reviewing Office of Inspector General concludes that the system of quality control for the reviewed Office of Inspector General has been suitably designed and complied with to provide it with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The Peer Review does not contain any deficiencies or significant deficiencies.

<sup>5</sup>A rating of **Compliant** conveys that the reviewed Office of Inspector General has adequate internal safeguards and management procedures to ensure that the Council of the Inspectors General on Integrity and Efficiency standards are followed and that law enforcement powers conferred by the 2002 amendments to the Inspector General Act are properly exercised.



**APPENDIX X**  
**Investigative Recoveries**  
 APRIL 1, 2017 TO SEPTEMBER 30, 2017

OIG Case Number	Case Category	Action	OPM Recovery (Net)	Total Recovery (All Programs/ Victims)	Fines, Penalties, Assessments, and Forfeitures
I 2011 00108	Healthcare Fraud	Civil Action	\$ 84,947	\$11,400,000	\$ 0
I 2011 00588	Healthcare Fraud	Civil Action	4,859,360	46,500,000	0
I-12-00311	Healthcare Fraud	Civil Action	0	0	0
I-13-00640	Healthcare Fraud	Civil Action	682,761	22,044,000	0
I-14-00016	Healthcare Fraud	Civil Action	3,549	175,000	0
I-14-00107	Healthcare Fraud	Civil Action	58,200	60,000	0
I-14-00975	Healthcare Fraud	Civil Action	411,986	4,225,000	0
I-14-01181	Healthcare Fraud	Civil Action	2,750	300,000	0
I-14-01407	Healthcare Fraud	Civil Action	20,786	50,000	0
I-15-00163	Healthcare Fraud	Civil Action	52,199	7,550,000	0
I-15-00273	Healthcare Fraud	Civil Action	12,477	36,770	0
I-15-01451	Healthcare Fraud	Civil Action	14,366	416,865	0
I-15-02451	Healthcare Fraud	Civil Action	2,102	417,675	0
I-16-00612	Healthcare Fraud	Civil Action	77,687	112,180	0
I-17-00130	Healthcare Fraud	Civil Action	111,906	4,000,000	0
I-17-00229	Healthcare Fraud	Civil Action	125,066	382,333	0
I-17-00229	Healthcare Fraud	Civil Action	0	0	0
C-16-00689	Healthcare Fraud	Financial Recovery	487	487	0
I 2009 00123	Healthcare Fraud	Sentenced	0	0	100
I 2010 00440	Healthcare Fraud	Sentenced	0	369,315	100
I 2010 00440	Healthcare Fraud	Sentenced	0	3,062,330	100
I 2010 00440	Healthcare Fraud	Sentenced	0	4,910,133	100
I-12-00675	Healthcare Fraud	Sentenced	0	0	100
I-12-00675	Healthcare Fraud	Sentenced	0	3,383	100
I-14-00386	Healthcare Fraud	Sentenced	0	63,421	200
I-14-00596	Healthcare Fraud	Sentenced	0	0	260,125,000
I-14-01112	Healthcare Fraud	Sentenced	351,496	351,496	0
I-15-00164	Healthcare Fraud	Sentenced	0	0	100
I-15-00164	Healthcare Fraud	Sentenced	0	0	100
I-15-00164	Healthcare Fraud	Sentenced	0	0	100



## APPENDIX X

## Investigative Recoveries

APRIL 1, 2017 TO SEPTEMBER 30, 2017

(Continued)

OIG Case Number	Case Category	Action	OPM Recovery (Net)	Total Recovery (All Programs/Victims)	Fines, Penalties, Assessments, and Forfeitures
I-15-00164	Healthcare Fraud	Sentenced	\$ 0	\$ 0	\$ 0
I-15-00164	Healthcare Fraud	Sentenced	0	0	0
I-15-00164	Healthcare Fraud	Sentenced	0	0	200
I-15-00164	Healthcare Fraud	Sentenced	0	0	100
I-15-00164	Healthcare Fraud	Sentenced	0	0	200
I-15-00412	Healthcare Fraud	Sentenced	0	0	0
I-15-01245	Healthcare Fraud	Sentenced	0	177,575	100
I-17-00288	Healthcare Fraud	Sentenced	3,463	38,921	126
<b>TOTAL</b>	<b>Healthcare Fraud</b>		<b>\$6,875,588</b>	<b>\$106,646,884</b>	<b>\$260,126,826</b>
C-15-01113	Retirement Fraud	Financial Recovery	89,181	89,181	0
I-16-00474	Retirement Fraud	Financial Recovery	159,026	159,026	0
C-16-00688	Retirement Fraud	Financial Recovery	107,864	107,864	0
C-17-00044	Retirement Fraud	Financial Recovery	48,425	48,425	0
C-17-00063	Retirement Fraud	Financial Recovery	79,154	79,154	0
C-17-00066	Retirement Fraud	Financial Recovery	38,423	38,423	0
I-14-00715	Retirement Fraud	Sentenced	48,226	646,301	200
I-14-00799	Retirement Fraud	Sentenced	246,240	246,240	100
I-15-00267	Retirement Fraud	Sentenced	112,249	185,370	100
<b>TOTAL</b>	<b>Retirement Fraud</b>		<b>\$928,788</b>	<b>\$1,599,984</b>	<b>\$400</b>
<b>GRAND TOTAL</b>			<b>\$7,804,376</b>	<b>\$108,246,868</b>	<b>\$260,127,226</b>



# Index of Reporting Requirements

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