



**U.S. OFFICE OF PERSONNEL MANAGEMENT
OFFICE OF THE INSPECTOR GENERAL
OFFICE OF AUDITS**

Final Audit Report

Audit of Blue Cross and Blue Shield of Massachusetts

**Report Number 1A-10-11-15-056
August 15, 2016**

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EXECUTIVE SUMMARY

Audit of Blue Cross and Blue Shield of Massachusetts

Report No. 1A-10-11-15-056

August 15, 2016

Why Did We Conduct the Audit?

The objectives of our audit were to determine whether Blue Cross and Blue Shield of Massachusetts (Plan) charged costs to the Federal Employees Health Benefits Program (FEHBP) and provided services to FEHBP members in accordance with the terms of its contract with the U.S. Office of Personnel Management. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to claim payments.

What Did We Audit?

The Office of the Inspector General (OIG) has completed a limited scope audit of the FEHBP operations of Blue Cross and Blue Shield of Massachusetts. The audit covered Blue Cross and Blue Shield of Massachusetts claim payments from January 1, 2012 through June 30, 2015, as reported in the Blue Cross and Blue Shield Association's Federal Employee Program Government-wide Service Benefit Plan Annual Accounting Statements.

What Did We Find?

Our audit identified several minor incidents of erroneous claim payments, but we do not believe that the errors are indicative of major systemic control problems. Therefore, we conclude the Plan's processing of FEHBP claims appears to be in compliance with the terms of its contract with the U.S Office of Personnel Management and industry standards. The report questions \$83,805 in health benefit charges. The questioned health benefit charges are summarized as follows:

A. Home Health Review

- The Plan incorrectly paid 281 claims containing home health services, resulting in overcharges of \$56,442 to the FEHBP.

B. Multiple Procedures Discount Review

- The Plan incorrectly paid eight claim lines that were billed when multiple services were performed on the same day, resulting in overcharges of \$14,592 to the FEHBP.

C. System Pricing Review

- The Plan incorrectly paid four claims when FEP was the primary insurer, resulting in overcharges of \$7,799 to the FEHBP.

D. Non-Participating Provider Review

- The Plan incorrectly paid two claims to providers that are not part of the Plan's provider network, resulting in overcharges of \$4,972 to the FEHBP.



Michael R. Esser
*Assistant Inspector General
for Audits*

ABBREVIATIONS

Association	Blue Cross Blue Shield Association
BCBS	Blue Cross Blue Shield
CFR	Code of Federal Regulations
DO	Director's Office
FEHB	Federal Employees Health Benefits
FEHBP	Federal Employees Health Benefits Program
FEP	Federal Employee Program
FEP OC	Federal Employee Program Operations Center
OBRA 93	Omnibus Budget Reconciliation Act of 1993
OIG	Office of the Inspector General
OPM	U.S. Office of Personnel Management
Plan	Blue Cross and Blue Shield of Massachusetts

TABLE OF CONTENTS

	<u>Page</u>
EXECUTIVE SUMMARY	i
ABBREVIATIONS	ii
I. BACKGROUND	1
II. OBJECTIVES, SCOPE, AND METHODOLOGY	3
III. AUDIT FINDINGS AND RECOMMENDATIONS.....	5
A. Home Health Review	5
B. Multiple Procedures Discount Review	6
C. System Pricing Review	7
D. Non-Participating Provider Review	8
IV. MAJOR CONTRIBUTORS TO THIS REPORT	11
 APPENDIX: Blue Cross Blue Shield Association’s May 26, 2016 response to the Draft Audit Report, issued April 11, 2016.	
 REPORT FRAUD, WASTE, AND MISMANAGEMENT	

I. BACKGROUND

This final audit report details the findings, conclusions, and recommendations resulting from our limited scope audit of the Federal Employees Health Benefits Program (FEHBP) operations at Blue Cross and Blue Shield of Massachusetts (Plan). The Plan is located in Boston, Massachusetts. The audit was performed by the U.S. Office of Personnel Management's (OPM) Office of the Inspector General (OIG), as authorized by the Inspector General Act of 1978, as amended.

The FEHBP was established by the Federal Employees Health Benefits (FEHB) Act (Public Law 86-382), enacted on September 28, 1959. The FEHBP was created to provide health insurance benefits for federal employees, annuitants, and dependents. OPM's Healthcare and Insurance Office has overall responsibility for administration of the FEHBP. The provisions of the FEHB Act are implemented by OPM through regulations, which are codified in Title 5, Chapter 1, Part 890 of the Code of Federal Regulations (CFR). Health insurance coverage is made available through contracts with various health insurance carriers.

The Blue Cross Blue Shield Association (Association), on behalf of participating Blue Cross and Blue Shield (BCBS) plans, has entered into a Government-wide Service Benefit Plan contract (CS 1039) with OPM to provide a health benefit plan authorized by the FEHB Act. The Association delegates authority to participating local BCBS plans throughout the United States to process the health benefit claims of its federal subscribers. There are 64 BCBS plans participating in the FEHBP.

The Association has established a Federal Employee Program (FEP¹) Director's Office (DO) in Washington, D.C. to provide centralized management for the Service Benefit Plan. The FEP DO coordinates the administration of the contract with the Association, member BCBS plans, and OPM.

The Association has also established an FEP Operations Center (OC). The activities of the FEP OC 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 (using computerized system edits), maintaining a history file of all FEHBP claims, and maintaining an accounting of all program funds.

¹ Throughout this report, when we refer to "FEP", we are referring to the Service Benefit Plan lines of business at the Plan. When we refer to the "FEHBP", we are referring to the program that provides health benefits to federal employees.

Compliance with laws and regulations applicable to the FEHBP is the responsibility of the Association and Plan management. Also, management of the Plan is responsible for establishing and maintaining a system of internal controls.

The most recent audit report issued that covered claim payments for Blue Cross and Blue Shield of Massachusetts was Report No. 1A-10-11-04-065, dated June 26, 2006. All findings from that audit have been resolved.

The results of this audit were provided to the Plan in written audit inquiries; were discussed with Plan and/or Association officials throughout the audit and at an exit conference; and were presented in detail in a draft audit report, dated April 11, 2016. The Association's comments offered in response to the draft report were considered in preparing our final report and are included as an Appendix to this report.

II. OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our audit were to determine whether the Plan charged costs to the FEHBP and provided services to FEHBP members in accordance with the terms of the contract. Specifically, our objective was to determine whether the Plan complied with contract provisions relative to health benefit payments.

Scope and Methodology

We conducted our limited scope performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient and appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We reviewed the Blue Cross and Blue Shield Association's Government-wide Service Benefit Plan FEP Annual Accounting Statements as they pertain to Plan codes 200 and 700 (BCBS of Massachusetts) for contract years 2012 through 2015. During this period, the Plan paid approximately \$2 billion in health benefit charges (See Figure 1). From this universe, we judgmentally selected various samples. We reviewed 776 claims, totaling approximately \$4.9 million in payments, for the period January 1, 2012 through June 30, 2015, for proper adjudication. We used the FEHBP contract, the 2012 through 2015 Service Benefit Plan brochures, the Plan's provider agreements, and the Association's FEP Administrative Procedures Manual to determine the allowability of benefit payments. The results of these samples were not projected to the universe of claims.

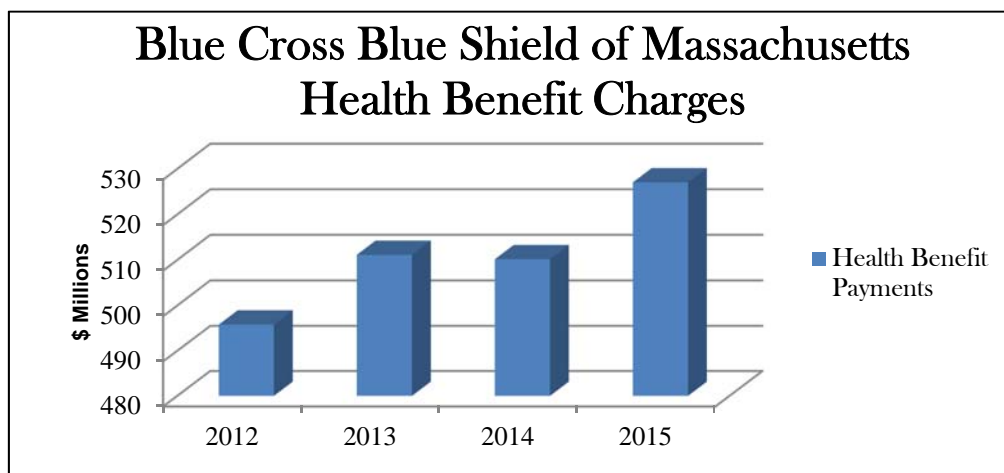


Figure 1 – Health Benefit Charges

In planning and conducting our audit, we obtained an understanding of the Plan's internal control structure to help determine the nature, timing, and extent of our auditing procedures. For those areas selected, we primarily relied on substantive tests of transactions and not tests of controls. Based on our testing, we did not identify any significant matters involving the Plan's internal control structure and its operations. However, since our audit would not necessarily disclose all significant matters in the internal control structure, we do not express an opinion on the Plan's system of internal controls taken as a whole.

We also conducted tests to determine whether the Plan had complied with the contract and the laws and regulations governing the FEHBP as they relate to claim payments. The results of our tests indicate that, with respect to the items tested, the Plan did not fully comply with the provisions of the contract relative to claim payments. Exceptions noted are explained in detail in the "Audit Findings and Recommendations" section of this audit report. With respect to the items not tested, nothing came to our attention that caused us to believe that the Plan had not complied, in all material respects, with those provisions.

In conducting our audit, we relied to varying degrees on computer-generated data provided by the FEP DO, the FEP OC, and the Plan. Through audits and a reconciliation process, we have verified the reliability of the BCBS claims data in our data warehouse, which was used to identify the universe of claims for each type of review. The BCBS claims data is provided to us on a monthly basis by the FEP OC, and after a series of internal steps, uploaded into our data warehouse. However, due to time constraints, we did not verify the reliability of the data generated by the Plan's local claims system. While utilizing the computer-generated data during our audit, nothing came to our attention to cause us to doubt its reliability. We believe that the data was sufficient to achieve our audit objectives.

Audit fieldwork was performed at our offices in Washington, D.C.; Cranberry Township, Pennsylvania; and Jacksonville, Florida through March 2016.

III. AUDIT FINDINGS AND RECOMMENDATIONS

A. Home Health Review

\$56,442

For the scope of January 1, 2012 through June 30, 2016, we identified all claims containing Home Health services. Based on our sample review, we identified a system error impacting one provider, Partners Healthcare. As a result, we reviewed all claims paid between March 1, 2015 and October 31, 2015, for this provider. See Exhibit I for a summary of our Home Health Review.

Exhibit I – Summary of Home Health Review

Universe of Claims	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
██████████	\$██████████	381	\$65,805	281	\$56,442

Sample selection Criteria:

- Randomly selected 100 claims stratified by facility bill type; and
- Selected all home health claims for Partners Healthcare reimbursed from March 1, 2015 to October 31, 2015.

Cause of Error:

Our review determined that the Plan’s local system was incorrectly paying one provider at billed charges, instead of applying the provider’s lower contracted rate. This was caused by a programming error during the implementation of a system enhancement in March 2015. The impact was limited to one home health provider, Partners Healthcare, for claims reimbursed after February 2015. As of February 5, 2016, the Plan has implemented system corrections and initiated recoveries on all claim payment errors.

As a result of this review, we determined the Plan incorrectly paid 281 claims, resulting in overcharges of \$56,442 to the FEHBP.

Contract CS 1039, Part III, section 3.2 (b) (1) states, “The Carrier may charge a cost to the contract for a contract term if the cost is actual, allowable, allocable, and reasonable.” Additionally, Part II, section 2.3(g) states, “If the Carrier [or OPM] determines that a Member’s claim has been paid in error for any reason . . . the Carrier shall make a prompt and diligent effort to recover the erroneous payment”

BCBS Association Response:

“The Plan agrees that it incorrectly reimbursed claims totaling \$56,442 to one contracted provider. . . . When the issue was identified, a processing work around was developed and implemented on July 17, 2015 to ensure that the claims were processing at the correct allowance. A system change was implemented on February 5, 2016 to correct this issue. . . . All claims impacted have been identified, corrected and overpayment recovery has been initiated to recover the overpayments. Any amounts recovered will be returned to the Program.”

OIG Comments:

As part of the audit resolution process, we recommend that the Plan provide OPM’s Healthcare and Insurance Office with evidence that these overpayments have been properly adjusted and returned to the FEHBP. This statement applies to all subsequent recommendations in this report where the Plan agrees to implement our recommendations.

Recommendation 1

We recommend that the contracting officer disallow \$56,442 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

B. Multiple Procedures Discount Review \$14,592

We reviewed a sample of claims that contained multiple procedures. In general, the Plan discounts the provider’s reimbursement rate when multiple services are performed on the same patient on the same day. See Exhibit II for a summary of our Multiple Procedures Discount Review.

Exhibit II – Summary of Multiple Procedures Discount Review

Universe of Claim Lines	Universe Dollar Total	Sampled Claim Lines	Sampled Dollar Total	Claim Lines Paid in Error	Total Claim Payment Errors
██████████	\$ ██████████	139	\$332,885	8	\$14,592

Sample Selection Criteria:

- Randomly selected 100 claim lines with amounts paid greater than \$500; and

- All claims lines subject to Omnibus Budget Reconciliation Act of 1993 (OBRA 93) pricing guidelines with amounts paid of \$200 or more².

Cause of Errors:

- The Plan incorrectly paid seven claim lines due to a processor keying the wrong information, resulting in overcharges of \$13,503 to the FEHBP.
- The FEP OC did not apply the Medicare multiple procedure discount to one OBRA 93 claim line, resulting in an overcharge of \$1,089.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

BCBS Association Response:

The Plan states, “[they] initiated recovery on confirmed overpayments and will return any funds recovered to the FEP Program.”

Recommendation 2

We recommend that the contracting officer disallow \$14,592 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

C. System Pricing Review

\$7,799

For claims reimbursed during the period of July 1, 2012 through June 30, 2015, we reviewed a sample where the FEHBP paid as the primary insurer to ensure the Plan’s local system properly processed and priced these claims in accordance with the Plan’s provider contracts. See Exhibit III for a summary of our System Pricing Review.

Exhibit III – Summary of System Pricing Review

Universe of Claim Lines	Universe Dollar Total	Sampled Claims	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
██████████	\$ ██████████	160	\$2,453,606	4	\$7,799

² The OBRA 93 regulation limits the benefit payment for certain services to annuitants age 65 or older who are not covered under Medicare Part B and the FEHBP is required to limit the claim payment to the lesser of the Medicare Part B payment or billed charges.

Sample Selection Criteria:

We selected 160 claims that were stratified by place of service, such as provider’s office or inpatient hospital, and payment category, such as \$50 to \$99. Our sample was judgmentally determined by the number of sample items from each place of service stratum based on the stratum’s total claim dollars paid.

Cause of Errors:

The overpayments found in this review were due to manual processing errors such as the processor manually entering the incorrect percentage used to calculate the allowed amount.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

BCBS Association Response:

The Plan states, “[they] initiated recovery on confirmed overpayments and will return any funds recovered to the FEP Program.”

Recommendation 3

We recommend that the contracting officer disallow \$7,799 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

D. Non-Participating Providers Review

\$4,972

We reviewed a sample of claims paid to providers that are not a part of the Plan’s preferred provider network (non-par), to ensure the Plan is properly paying claims in accordance with the FEP non-par pricing guidelines. See Exhibit IV for a summary of our Non-Participating Providers Review.

Exhibit IV – Summary of Non-Participating Providers Review

Universe of Claim Lines	Universe Dollar Total	Sampled Claim Lines	Sampled Dollar Total	Claims Paid in Error	Total Claim Payment Errors
██████	\$██████	28	\$213,972	2	\$4,972

Sample selection Criteria:

- Selected all outpatient surgery claims where the amount paid was greater than or equal to the amount billed; and
- All inpatient claims where the amount paid was greater than or equal to the amount billed and the total claim amount paid was \$9,000 or more.

Cause of Errors:

The Plan incorrectly paid two claims, totaling \$4,972 in overcharges to the FEHBP, due to manual processing errors. For one claim, the processor applied the incorrect provider information during the pricing of the claim which caused the incorrect allowance to be applied. For the other claim, the processor allowed the claim to process payment for a terminated member.

Procedural Issue:

Our review determined that the Plan does not have policies or procedures in place to ensure that the claim amounts paid as recorded in the Plan's local system equal the amounts paid recorded in the Association's FEP Express nation-wide claims processing system. For five claims the Plan's claim processors did not properly adjust the FEP Express system to reflect the actual paid amount on the claims, resulting in variances of \$76,073. These variances resulted in an overstatement of the amounts paid in the FEP Express system and the health benefit charges reported on the Blue Cross Blue Shield Association's Government-wide Service Benefit Plan Annual Accounting Statements (AAS). Since claims expense is considered when developing premium rates, overstating the claims expense in the AAS may increase future rates.

As previously cited from CS 1039, costs charged to the FEHBP must be actual, allowable, allocable, and reasonable. If errors are identified, the Plan is required to make a diligent effort to recover the overpayments. Also, the recovery of any overpayment must be treated as an erroneous benefit payment, regardless of any time period limitations in the written provider agreement.

The FEP Administrative Manual, Volume III, Chapter 3 states, "Plans should have an internal control system in place for FEP claim payments . . . Specifically, Plans should maintain internal control systems to confirm . . . Claim adjustments made on the local Plan system are also made on the FEPEXpress system so the amount paid on both system agrees"

BCBS Association Response:

The Plan states, "*[they] initiated recovery on confirmed overpayments and will return any funds recovered to the FEP Program*"

“BCBSMA [the Plan] corporate accounting is working with NASCO to implement a new project in 2016 that will assist the Plan in performing reconciliations. NASCO will identify records / claims that are out of balance and report them to the Plan, reducing the need for manual effort by the Plans [to] perform reconciliations on a weekly and/or monthly basis. The project is on target for implementation in November 2016.”

Recommendation 4

We recommend that the contracting officer disallow \$4,972 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Recommendation 5

We recommend that the contracting officer verify that the Plan implements the corrective actions related to the procedural issue outlined in the Plan’s response to the draft report.

IV. MAJOR CONTRIBUTORS TO THIS REPORT

Information Systems Audits Group

██████████, Auditor-in-Charge

████████████████████, Auditor

██████████, Senior Team Leader

██████████, Group Chief

APPENDIX



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

May 26, 2016

[REDACTED]
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Federal Employee Program
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**Reference: OPM DRAFT AUDIT REPORT
Blue Cross Blue Shield of Massachusetts
Audit Report Number 1A-10-11-15-056
(Dated and Received April 11, 2016)**

Dear [REDACTED]:

This is our response to the above referenced U.S. Office of Personnel Management (OPM) Draft Audit Report covering the Federal Employees' Health Benefits Program (FEHBP) for Blue Cross Blue Shield of Massachusetts (Plan). Our comments concerning the recommendations in this report are as follows:

HEALTH BENEFIT CHARGES

A. Home Health Review

\$56,442

Recommendation 1

We recommend that the contracting officer disallow \$56,442 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees that it incorrectly reimbursed claims totaling \$56,442 to one contracted provider. From March 6, 2015 thru July 17, 2015, the Plan paid claims at charges rather than the network allowance due to a mapping error. When the issue was identified, a processing work around was developed and implemented on July

17, 2015 to ensure that the claims were processing at the correct allowance. A system change was implemented on February 5, 2016 to correct this issue.

The Plan would like to note that this issue was initially identified by BCBSMA through internal QA processes, prior to the OPM selecting the Home Healthcare sample. In accordance with BCBSMA internal procedures, efforts were immediately initiated to identify and mitigate the root cause, and to identify and correct all claims impacted by the issue. All claims impacted have been identified, corrected and overpayment recovery has been initiated to recover the overpayments. Any amounts recovered will be returned to the Program.

A final impact assessment for this issue was provided to the OIG on March 24, 2016.

B. Multiple Procedures Discount Review **\$17,784**

Recommendation 2

We recommend that the contracting officer disallow \$17,784 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees to overpayments totaling \$14,592 and contests overpayments totaling \$4,281. The Plan noted that:

- For one sample, totaling \$13,503, the payment was not calculated correctly. The incorrect payment was the result of a manual processing error where the claim rejected lines as inclusive but the associate did not remove pricing on the claim lines, resulting in an overpayment of \$13,503 to FEP. The associate has been educated and the claim adjusted to pay correctly.
- For one sample (sample #100), the Plan initially agreed was an overpayment; however, upon further review, the Plan determined that the claim processed correctly. Documentation to support that the claim was processed correctly was provided to the OIG on March 24, 2016.
- For one sample (OBRA'93 sample #30) the Plan continues to disagree that this was a processing error based upon the details of the Plan's initial response. OIG continues to cite as an error for the full amount of the claim \$3,018; however, only \$1,089 paid in error; the difference relates to pro-rating of the claim payment that did not occur.

The Plan initiated recovery on confirmed overpayments and will return any funds recovered to the FEP Program.

C. Non-Participating Providers Review

\$10,781

Recommendation 3

We recommend that the contracting officer disallow \$10,781 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

Plan agrees with overpayments totaling \$4,972 and contests overpayments totaling \$5,809. The Plan noted that:

- For sample 1, the Plan agrees that the claim was paid in error as the associate manually overrode the system edit and paid the claim for a termed member resulting in an FEP overpayment \$4,388.
- For sample 2, the plan agrees that the claim was paid in error as the associate manually put the “P1” in the performing provider network status claim field. This resulted in the provider appearing as a preferred provider and the claim paid in-network benefits in error, resulting in an FEP overpayment of \$584.
- For sample 21, Plan disagrees that a payment error totaling \$5,809 occurred. The claim was processed correctly prior to the audit and was in review during the audit. A revised spreadsheet and screenshots of the finalized adjustment was provided to the OIG on March 24, 2016.

The Plan initiated recovery on confirmed overpayments and will return any funds recovered to the FEP Program.

Recommendation 4

We recommend that the contracting officer require the Plan to implement a reconciliation process that ensures that the claim amounts paid in the Plan’s local system equals the amounts paid in the FEP Express system. Additionally, the contracting officer should ensure the Plan takes corrective actions to implement these procedures.

Plan Response

BCBSMA corporate accounting is working with NASCO to implement a new project in 2016 that will assist the Plan in performing reconciliations. NASCO will identify records / claims that are out of balance and report them to the Plan, reducing the need for manual effort by the Plans perform reconciliations on a weekly and/or monthly basis. The project is on target for implementation in November 2016.

D. System Pricing Review

\$7,799

Recommendation 5

We recommend that the contracting officer disallow \$7,799 for claim overcharges and verify that the Plan returns all amounts recovered to the FEHBP.

Plan Response

The Plan agrees with overpayments totaling \$7,799. The Plan initiated recovery on the confirmed overpayments and will return any funds recovered to the FEP Program.

We appreciate the opportunity to provide our response to each of the findings in this report and request that our comments be included in their entirety and are made a part of the Final Audit Report. If you have any questions, please contact me at [REDACTED] or [REDACTED] at [REDACTED].

Sincerely,

[REDACTED], CISA
Managing Director, FEP Program Assurance

cc: [REDACTED], BCBSMA



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