DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services – Region III
Public Ledger Building, Suite 316
150 South Independence Mall West
Philadelphia, PA 19106-3499

February 9, 2007

Report Number: A-03-05-00205

Mr. Patrick W. Finnerty
Director, Department of Medical Assistance Services
600 East Broad Street
Richmond, Virginia 23219

Dear Mr. Finnerty:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Virginia Rebase Process Used to Calculate Medicaid Rates for State Fiscal Years 2001 Through 2003." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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If you have any questions or comments about this report, please do not hesitate to contact me at (215) 861-4470 (e-mail Stephen.Virbitsky@oig.hhs.gov), or your staff may contact Bernard Siegel, Audit Manager, at (215) 861-4484 (e-mail Bernard.Siegel@oig.hhs.gov). Please refer to report number A-03-05-00205 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosures—as stated

cc:
Scott Crawford
William Lessard
Charles Lawver

Direct reply to HHS Action Official:

Nancy B. O'Connor
Regional Administrator
Centers for Medicare & Medicaid Services, Region III
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

VIRGINIA REBASE PROCESS USED TO CALCULATE MEDICAID RATES FOR STATE FISCAL YEARS 2001 THROUGH 2003

Daniel R. Levinson
Inspector General

February 2007
A-03-05-00205

Office of Inspector General

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Virginia uses a prospective payment system to reimburse hospitals for Medicaid inpatient stays. Under this system, reimbursement includes a preestablished amount for each discharge based on a diagnosis-related group (DRG) code that defines various medical and surgical cases based on type and complexity. The DRG payment system includes a DRG payment for each case and an outlier payment for cases with extraordinarily high costs. The State plan defines the DRG payment amount as the hospital-specific operating rate per case multiplied by a DRG weighting factor. The Federal Government pays its share according to a formula defined in section 1905(b) of the Social Security Act. During the audit period, the Federal share for Virginia ranged between 50.5 and 54.4 percent.

The State rebases the DRG payment system every 1 to 3 years during its recalibration and rebasing process. Each time the State rebases rates, it establishes a new base year. Section 12VAC30-70-221(C) of the Virginia Administrative Code defines the base year as "the state fiscal year for which data is used to establish the DRG relative weights, the hospital specific case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated." Rates established from base-year data are used in subsequent State fiscal years (FYs). Virginia used base-year cost report data from State FY 1998 to recalibrate and rebase the rates used to make payments for State FYs 2001 through 2003.

Annually, hospitals submit preliminary unaudited cost reports to Virginia that are called "as-filed" cost reports. The as-filed cost report data are entered in the cost report file and are updated and replaced by tentatively settled data at the completion of audits performed by the State or one of its contract auditors. State auditors will revise tentatively settled data until the Medicare cost report is finalized.

The State aggregates cost data from the two State-owned teaching hospitals, the Medical College of Virginia and the University of Virginia Health Systems, and establishes a single statewide operating rate per case for those two hospitals. Accordingly, any change in base-year data on either cost report will affect subsequent DRG and outlier payments to both hospitals. Cost report data for the 93 non-State-owned acute care hospitals are collectively used to establish a single statewide operating rate per case for those acute care hospitals.

OBJECTIVE

Our objective was to determine whether Virginia used allowable cost report data to establish rates used to calculate Medicaid DRG base and outlier payments to the two State-owned teaching hospitals during State FYs 2001 through 2003.

SUMMARY OF FINDING

Virginia did not use allowable cost report data to establish rates used to calculate Medicaid DRG base and outlier payments to State-owned teaching hospitals. Instead, Virginia used as-filed cost report data, which included overstated bed days and other unallowable costs, to develop the hospital-specific operating rates per case and cost-to-charge ratios. Virginia stated that its State plan allowed the use of as-filed cost reports to develop the hospital-specific operating rates per case and cost-to-charge ratios. However, the State's contract auditor identified material misstatements and unallowable costs in as-filed cost report data using Medicare principles of cost reimbursement. Although Virginia and the Medical College of Virginia agreed that the as-filed cost report included material misstatements and unallowable costs, Virginia did not adjust its rates until the next rebasing period—in this case, 3 years later.

If Virginia had used tentatively settled cost report data instead of as-filed cost report data for the two State-owned teaching hospitals, it would have reduced payments to the two State-owned teaching hospitals by $18,088,512 ($9,351,348 Federal share) during State FYs 2001 through 2003.

RECOMMENDATION

We recommend that Virginia consider amending its State plan to revise the operating rates per case and cost-to-charge ratios when material misstatements in a hospital's base-year cost report data are identified after the State rebases.

VIRGINIA AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments, Virginia did not concur with the specific recommendation. However, Virginia stated that it has taken steps to reduce the possibility of using cost-to-charge ratios with material misstatements in the context of the rebasing process. Administratively it now uses desk audited cost reports as the source for hospital cost-to-charge ratios in the rebasing process. Virginia admits that it will use as-filed cost reports when delays require it, but states that it now carefully reviews the ratios for reasonableness to ensure that they do not contain significant errors.

In addition, Virginia stated that it has made State plan changes to the rebasing process, for other reasons, that also reduce the potential impact of such a misstatement. Virginia has amended its State plan so that the operating rate for Type One hospitals is based on the operating rate for Type Two hospitals. Because there are more than 90 Type Two hospitals, one cost-to-charge ratio can no longer have such a dramatic impact on the operating rate.

In its comments, CMS believes that the changes already incorporated by the State of Virginia and the proposed administrative steps will be sufficient to correct and identify material errors in calculating the prospective rate.

Virginia's comments are included as Appendix A and CMS's comments are included as Appendix B.

OFFICE OF INSPECTOR GENERAL RESPONSE

Although Virginia's actions differ from the audit recommendations, the State has taken steps to minimize the impact that material misstatements on a hospital's submitted cost report would have on Medicaid reimbursements. These actions are positive and in line with our recommendation.

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INTRODUCTION

BACKGROUND

Medicaid Program

Title XIX of the Social Security Act (the Act) established Medicaid as a joint Federal and State program. Medicaid provides medical assistance to eligible low-income persons. Each State administers its Medicaid program in accordance with a State plan that the Centers for Medicare & Medicaid Services (CMS) approves for compliance with Federal laws and regulations. Within broad Federal rules, each State decides the payment levels for services and administrative and operating procedures. The Federal Government pays its share according to a formula defined in section 1905(b) of the Act. During the audit period, the Federal share for Virginia ranged between 50.5 and 54.4 percent.

The Virginia State plan incorporates sections of the Virginia Administrative Code dealing with Medicaid hospital payments (12VAC30-70). The Department of Medical Assistance Services administers the Medicaid program in Virginia.

Virginia's Medicaid Reimbursement for Inpatient Hospital Cases

Virginia uses a prospective payment system to reimburse hospitals for Medicaid inpatient stays. Under this system, reimbursement includes a preestablished amount for each discharge based on a diagnosis-related group (DRG) code that defines various medical and surgical cases based on type and complexity. The DRG payment system includes a DRG payment for each case and an outlier payment for cases with extraordinarily high costs. The State plan defines the DRG payment amount as the hospital-specific operating rate per case multiplied by a DRG weighting factor.[1]

The State rebases the DRG payment system every 1 to 3 years during its recalibration and rebasing process.[2] Section 12VAC30-70-221(C) of the Virginia Administrative Code defines the base year as "the state fiscal year for which data is used to establish the DRG relative weights, the hospital specific case-mix indices, the base year standardized operating costs per case, and the base year standardized operating costs per day. The base year will change when the DRG payment system is rebased and recalibrated." Rates established from base-year data are used in subsequent State fiscal years (FYs). Virginia used base-year cost report data from State FY 1998 to recalibrate and rebase the rates used to make payments for State FYs 2001 through 2003.

Annually, hospitals submit preliminary unaudited cost reports to Virginia that are called "as-filed" cost reports. The as-filed cost report data are entered in the cost report file and are updated and replaced by tentatively settled data at the completion of audits performed by the

[1]The hospital-specific operating rate per case is determined from the base-year standardized operating costs per case.

[2]The recalibration process evaluates and adjusts the DRG relative weights and hospital case-mix indices. The rebasing process reviews and updates the base-year standardized operating costs per case and the base-year standardized operating costs per day.

State or one of its contract auditors. State auditors will revise tentatively settled data until the Medicare cost report is finalized.

The State aggregates cost data from the two State-owned teaching hospitals, the Medical College of Virginia and the University of Virginia Health Systems, and establishes a single statewide operating rate per case for those two hospitals.[3] Accordingly, any change in base-year data on either cost report will affect subsequent DRG and outlier payments to both hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Virginia used allowable cost report data to establish rates used to calculate Medicaid DRG base and outlier payments to the two State-owned teaching hospitals during State FYs 2001 through 2003.

Scope

We reviewed selected portions of the Virginia rate-setting process for State FYs 2001 through 2003.[4] Virginia paid approximately $702 million in Medicaid operating payments for inpatient hospital services during that period: $642 million for DRG base payments and $60 million for cost outlier payments. We limited our review to the two State-owned teaching hospitals, which received more than 26 percent of Virginia's Medicaid hospital inpatient payments during State FYs 2001 through 2003.

We focused our review on the State's rebasing process and did not review the recalibration process.

A draft audit report was provided to Virginia on November 23, 2005, and Virginia responded to that draft on January 20, 2006. After reviewing Virginia's response, we modified the finding and recommendations. We issued the modified draft report on November 17, 2006, for comment.

We performed this review at the Virginia Department of Medical Assistance Services in Richmond, Virginia, the Medical College of Virginia in Richmond, Virginia, and the University of Virginia Health Systems in Charlottesville, Virginia.

Methodology

We conducted interviews and reviewed documentation to determine how Virginia rebased its rates used in the calculation of Medicaid DRG base and outlier payments. We also reviewed those portions of the Virginia Administrative Code incorporated into the State plan that identified the methodology used to calculate hospital-specific operating rates per case and the cost-to-charge ratio for each hospital from Medicaid cost report data.

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[3]Cost report data for the 93 non-State-owned acute care hospitals are collectively used to establish a single statewide operating rate per case for those acute care hospitals.

[4]A second report, "Medicaid Hospital Outlier Payments in Virginia for State Fiscal Years 2001 Through 2003" (A-03-04-00212) covers the additional impact of using outdated cost-to-charge ratios on the prospective (DRG-based) payment system.

We used cost data from tentatively settled 1998 cost reports, which included audit adjustments to as-filed data reported by the two State-owned teaching hospitals, to recalculate the hospital-specific cost-to-charge ratio and operating rate for each hospital, then used those rates to recalculate all Medicaid payments to the two hospitals during State FYs 2001 through 2003.[5] We compared the amounts paid by Virginia with the payment amounts using the audit-determined rates to determine the impact on Medicaid hospital inpatient payments and calculated the amounts attributed to the changes in the hospital-specific cost-to-charge ratio and the operating rate for each of the two hospitals.

We performed the review in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATION

Virginia did not use allowable cost report data to establish rates used to calculate Medicaid DRG base and outlier payments to State-owned teaching hospitals. Instead, Virginia used as-filed cost report data, which included overstated bed days and other unallowable costs, to develop the hospital-specific operating rates per case and cost-to-charge ratios. Virginia stated that its State plan allowed the use of as-filed cost reports to develop the hospital-specific operating rates per case and cost-to-charge ratios. However, the State's contract auditor identified material misstatements and unallowable costs in as-filed cost report data using Medicare principles of cost reimbursement. Although Virginia and the Medical College of Virginia agreed that the as-filed cost report included material misstatements and unallowable costs, Virginia did not adjust its rates until the next rebasing period—in this case, 3 years later.

If Virginia had used tentatively settled cost report data instead of as-filed cost report data for the two State-owned teaching hospitals, it would have reduced payments to the two State-owned teaching hospitals by $18,088,512 ($9,351,348 Federal share) during State FYs 2001 through 2003.

VIRGINIA'S REBASING PROCESS

Section 12VAC30-70-221(C) of the Virginia Administrative Code defines "cost" to mean allowable cost as defined in the Virginia Administrative Code and by Medicare principles of reimbursement.

Virginia rebases and recalibrates its prospective payment rates at least every 3 years, primarily using cost data captured in the cost report file and claims history file. Final prospective rates are the results of various prospective adjustments, including assumed inflation, applied to the base year standardized costs in order to reflect cost trends expected in the rate years. The State aggregates the data of the two State-owned teaching hospitals to develop their prospective rates. The two hospitals account for approximately 26 percent of Virginia's total inpatient Medicaid payments.

[5]The cost data on the tentatively settled cost reports included corrections to as-filed data that was reviewed by Virginia and its contract auditors before the start of State FY 2001.

Virginia stated that its rebasing methodology was not designed to reimburse at cost for all cases, but rather to reimburse at what is expected to be cost at the time of the prospective calculation. Virginia further stated that once established, the hospital-specific operating rates per case and cost-to-charge ratio for all hospitals under a prospective payment system should not be changed for up to 3 years, the maximum period between rebasing of rates allowed by the State plan.

Virginia used as-filed cost reports to develop the hospital-specific operating rates per case and cost-to-charge ratios used to establish prospective payment rates for the two State-owned teaching hospitals. During the rebasing using State FY 1998 cost report data, Virginia was undergoing an upgrade in its systems that contributed to the delinquency and untimely review of hospital cost reporting data.

Virginia stated that when it established its prospective payment rates, the as-filed cost report data was considered sufficiently reliable to perform its rebasing and recalibration process.

MEDICAL COLLEGE OF VIRGINIA'S COST REPORT

On January 11, 2000, the Medical College of Virginia submitted its State FY 1998 cost report—410 days after it was due. Virginia directed its auditors to review the hospital's State FY 1998 indigent-care cost report. On April 3, 2000, at the start of the audit, the hospital notified the auditors that its State FY 1998 cost reports included unallowable costs related to its physician practice plan and that it was removing those costs from its Medicare cost report. Virginia's auditors subsequently removed those costs from its Medicaid and indigent-care cost reports.

On April 10, 2000, Virginia accumulated all hospital cost report data that was used to calculate the hospital specific operating rates and cost-to-charge ratios for the State FY 2001 DRG-based prospective payment system.

When Virginia and its auditors desk reviewed the Medical College of Virginia's as-filed cost report during April 25-27, 2000, they noted that the cost report materially overstated Medicaid bed days and included other unallowable costs that resulted in routine cost report adjustments. The State tentatively settled the cost report on May 4, 2000. Virginia agreed that the as-filed cost report for the Medical College of Virginia included unallowable costs, as defined by Medicare cost principles, but stated that it did not have this information when it rebased.

Although Virginia had become aware of the material misstatements identified during its desk audit of the Medical College of Virginia as-filed cost report, no actions were taken to adjust the rates established on May 30, 2000, and implemented on July 1, 2000. Virginia did not adjust those rates during the next 3 years, although it had determined that the misstatements in the cost report data would result in significant increases to the prospective rates of the two State-owned teaching hospitals.

EFFECT OF USING MATERIALLY MISSTATED MEDICAID COST REPORT DATA

Using as-filed cost reports, Virginia established a cost-to-charge ratio of 61.11 percent for the Medical College of Virginia and 57.49 percent for the University of Virginia Health Systems. If Virginia had used tentatively settled cost data, the cost-to-charge ratios would have been 52.49

and 55.98 percent, respectively, and the hospital-specific operating rates per case using the tentatively settled cost data would have decreased.[6]

If Virginia had used tentatively settled cost data to establish the prospective payment rates for the two State-owned teaching hospitals, or if Virginia had adjusted those rates at the start of the 3-year period, it would have reduced payments to the two State-owned teaching hospitals by $18,088,512 ($9,351,348 Federal share) during State FYs 2001 to 2003.

RECOMMENDATION

We recommend that Virginia consider amending its State plan to revise the operating rates per case and cost-to-charge ratios when material misstatements in a hospital's base-year cost report data are identified after the State rebases.

VIRGINIA AND THE CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In its comments, Virginia did not concur with the specific recommendation. However, Virginia stated that it has taken steps to reduce the possibility of using cost-to-charge ratios with material misstatements in the context of the rebasing process. Administratively it now uses desk audited cost reports as the source for hospital cost-to-charge ratios in the rebasing process. Virginia admits that it will use as-filed cost reports when delays require it, but states that it now carefully reviews the ratios for reasonableness to ensure that they do not contain significant errors.

In addition, Virginia stated that it has made State plan changes to the rebasing process, for other reasons, that also reduce the potential impact of such a misstatement. Virginia has amended its State plan so that the operating rate for Type One hospitals is based on the operating rate for Type Two hospitals. Because there are more than 90 Type Two hospitals, one cost-to-charge ratio can no longer have such a dramatic impact on the operating rate.

In its comments, CMS believes that the changes already incorporated by the State of Virginia and the proposed administrative steps will be sufficient to correct and identify material errors in calculating the prospective rate.

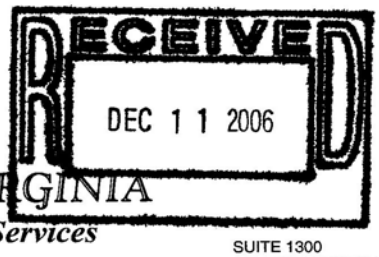
Virginia's comments are included as Appendix A and CMS's comments are included as Appendix B.

[6]We estimated the change in the operating rates per case for the two State-owned teaching hospitals based on estimated changes using final cost report data for the Medical College of Virginia that were calculated by Virginia personnel.

OFFICE OF INSPECTOR GENERAL RESPONSE

Although Virginia's actions differ from the audit recommendations, the State has taken administrative steps to reduce the possibility of using cost-to-charge ratios with material misstatements in its rebasing. In addition, linking the operating rates for Type One hospitals to Type Two hospitals should minimize the impact that material misstatements on a hospital's submitted cost report would have on Medicaid reimbursements. These actions are positive and in line with our recommendation.

APPENDIXES



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December 7, 2006

Mr. Stephen Virbitsky
Regional Inspector General
Department of Health and Human Services
150 S. Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Report Number: A-03-05-00205

Dear Mr. Virbitsky:

This letter is in response to your letter to Scott Crawford dated November 17, 2006, which enclosed a draft report entitled, "Virginia Rebase Process Used to Calculate Medicaid Rates for State Fiscal Years 2001 through 2003" (Report Number A-03-05-00205). You asked DMAS to provide written comments and a statement of concurrence or non-concurrence with each recommendation.

The report recommends that "Virginia consider amending its State plan to revise the operating rates per case and cost-to-charge ratios when material misstatements in a hospital's base-year cost report data are identified after the State rebases." We were previously aware of the likelihood of this recommendation emerging from the audit, and were familiar with the findings on which it is based. As a result, DMAS has taken administrative steps to reduce the possibility of using cost-to-charge ratios with material misstatements in the context of the rebasing process. In addition, DMAS has made State Plan changes to the rebasing process, for other reasons, that also reduce the potential impact of such a misstatement. Both of these changes are described below. We believe these changes will effectively address the issue identified in the audit. Further, in the context of the Virginia reimbursement system, the specific action recommended in the report could only be adopted after extensive consultation with provider representatives. The recommended action would create the possibility of a retroactive change to prospective rates. This would represent a policy departure that would not be welcomed by the provider community, and that would go in a direction opposite to what all parties in Virginia prefer. Therefore, DMAS does not believe it necessary or desirable at this time to adopt additional State Plan changes.

Administrative Steps

DMAS is rebasing hospital rates for FY08. During this rebasing, DMAS will be using desk audited cost reports as the source for hospital cost-to-charge ratios. In addition, during this year's rebasing process, DMAS has carefully reviewed cost-to-charge ratios for reasonableness by comparing cost-to-charge ratios from one year to the next to identify any unusual changes for further investigation. This review should enable us to identify any cost-to-charge ratios that contain significant errors, and should prevent erroneous data from materially affecting provider rates. We believe that any errors that cannot be detected in this way would be too small to affect the statewide rate that the rebasing process yields, and therefore too small to affect the hospital specific prospective rates.

Report Number A-03-05-00205
Mr. Stephen Virbitsky
December 7, 2006

While DMAS will be using desk settled cost reports for this rebasing and will make every effort to do so in the future, this may not always be possible, particularly if there are delays in the deadline for filing Medicare cost reports as there has been in the past. In general, DMAS will use the cost reports from the most recently available fiscal year, even if some of them have not been desk settled. However, we will continue to review all cost-to-charge ratios for reasonableness, and will investigate those that appear to require explanation.

State Plan Changes

DMAS has different reimbursement policies for the two state teaching hospitals (Type One hospitals) than it does for other hospitals (Type Two hospitals). The cost-to-charge ratio is a significant component of the rebasing calculation of the operating rate. During the period reviewed by the OIG, operating rates were established for Type One hospitals independently of Type Two hospitals, using the cost-to-charge ratios of the two state teaching hospitals. The OIG audit determined that using the wrong cost-to-charge ratio for one of the two hospitals had a significant affect on the operating rate for Type One hospitals. Beginning in FY04, DMAS amended its State Plan so that the operating rate for Type One hospitals is linked to the operating rate for Type Two hospitals. The cost-to-charge ratios of Type One hospitals no longer have an impact on the Type One hospital operating rate, because the operating rate for Type One hospitals is based on the operating rate for Type Two hospitals. Because there are more than 90 Type Two hospitals, in future rebasing calculations no one cost-to-charge ratio can have as dramatic an impact on the operating rate as occurred in the instance identified by the audit.

To summarize, as a result of the findings of the audit DMAS has adopted procedures that sharply reduce the chance of an incorrect cost-to-charge ratio being included in the rebasing calculation. In addition, unrelated to the audit DMAS has changed the rebasing methodology so that an incorrect cost-to-charge ratio, even if it were used to calculate rates, would have a much smaller effect than in the instance identified in the audit. DMAS believes these actions are appropriate and sufficient. To provide for retroactive changes to rates when incorrect cost to charge ratios are discovered after the fact would be a significant and problematic change in the context of Virginia's reimbursement system. We do not believe this is necessary to address the problem identified by the audit, but believe the actions we have taken are adequate.

Finally, the revised draft includes a finding that, in rebasing rates, DMAS did not use "allowable cost report data." We believe this is an incorrect statement. The implication that allowable cost data is only derived from audited cost report data is not supported in our State Plan or in federal regulations, nor is it a practical interpretation for prospective rate setting given the lengthy time period in which cost reports are often audited and/or reopened multiple times.

Thank you for the opportunity to comment on the draft report. If there are any questions, please contact William Lessard, Director of Provider Reimbursement, at (804) 225-4593.

Sincerely,

Patrick W. Finnerty

cc. William Lessard
Scott Crawford
Charles Lawver

J:\CSA\CLOG\OIG Audit Rebasing 2001-2003.doc

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Memorandum

Centers for Medicare & Medicaid Services
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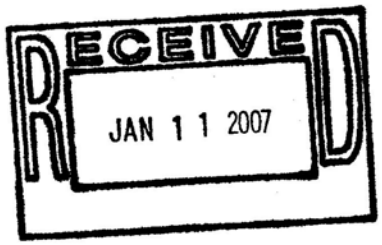

Date: JAN 9 2007

To: Regional Inspector General for Audit Services

From: Manager, Financial Review Branch
Division of Medicaid and Children's Health

Subject: Draft Audit Report – VA #A-03-05-00205

We have reviewed the subject revised draft audit report and the recommendations contained therein. We believe that the changes already incorporated by the State of Virginia and the proposed administrative steps will be sufficient to correct and identify material errors in calculating the prospective rate.

Thank you for giving us the opportunity to respond to your draft report. If you should have any questions regarding this matter, please contact Ginger Levesque of my staff at (215) 861-4645.

Ted Gallagher

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky (RIGA). Other principal Office of Audit Services staff who contributed includes:

Bernard Siegel, *Audit Manager*
Jack Kahriger, *Senior Auditor*
Paul Teti, *Auditor*
Daniel Malis, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.