Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS FOR ASSISTED LIVING PROGRAM BENEFICIARIES WHO ARE HOSPITALIZED

Daniel R. Levinson
Inspector General

MARCH 2006
A-02-05-01003

Office of Inspector General

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Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

March 9, 2006

Report Number: A-02-05-01003

Antonia C. Novello, M.D., M.P.H, Dr. P.H.
Commissioner
New York State Department of Health
Empire State Plaza
14th Floor, Room 1408
Corning Tower
Albany, New York 12237

Dear Dr. Novello:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Claims for Assisted Living Program Beneficiries Who Are Hospitalized." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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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To facilitate identification, please refer to report number A-02-05-01003 in all correspondence.

Sincerely yours,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
New York, New York 10278

EXECUTIVE SUMMARY

BACKGROUND

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care supervision, and home health services (either directly or under arrangements with other providers) to five or more adults. Services provided by ALPs are covered by New York's Medicaid State plan. The State's Medicaid program reimburses ALPs for nine services provided to Medicaid eligible residents via a per diem rate. The nine services included in the rate, for which no other Medicaid billing may occur, are: (1) personal care services, (2) home health aide services, (3) personal emergency response services, (4) nursing services, (5) physical therapy, (6) occupational therapy, (7) speech therapy, (8) medical supplies and equipment not requiring prior approval, and (9) adult day health care.

The Federal Office of Management and Budget Circular No. A-87 establishes principles and standards for determining allowable costs applicable to grants with State and local governments. Section C.,1.,c. of Attachment A of these principles states that in order to be allowable under a grant program, costs must be authorized or not prohibited under State or local laws or regulations. State regulations at New York Compilation of Codes, Rules and Regulations (NYCRR), Title 18, section 505.35(7) states that the Medicaid program will not make payments for assisted living program services provided to a Medicaid recipient while the recipient is receiving residential health care facility (nursing home) services or inpatient hospital services.

OBJECTIVE

Our objective was to determine whether ALPs within New York State (the State) were improperly claiming Medicaid reimbursement when their residents were in hospitals or nursing homes. Our audit covered the period January 1, 1999 through February 29, 2004.

SUMMARY OF FINDINGS

ALPs improperly claimed Medicaid reimbursement for their residents who were in hospitals, but not in nursing homes. Our audit identified 2,615 potentially improper Medicaid claims made by 53 ALPs for their residents who were in hospitals. The 2,615 claims totaled $277,363 ($140,479 Federal share). Appendix A of our report provides a listing of the 2,615 claims by ALP.

We selected a simple random sample of 30 of the 2,615 claims for review. For 29 of the 30 sampled claims, ALP providers improperly claimed Medicaid reimbursement for their residents who were in hospitals. For one sampled claim, a hospital incorrectly billed Medicaid using a wrong ALP beneficiary's Medicaid identification number. While the hospital claim was in error, the ALP sample claim was valid.

In our opinion, these unallowable claims occurred because: (1) the State did not have edits and controls in their Medicaid Management Information System (MMIS)[1] to detect claims made by

[1] Currently known as eMedNY

both an ALP and an inpatient hospital on the same date of service for the same beneficiary, and (2) ALP providers did not always follow State regulations that prohibited claims for their residents who were hospitalized.

RECOMMENDATIONS

We recommend that the State:

- institute eMedNY edits and ensure that they are effective to prevent ALPs from claiming and receiving Medicaid reimbursement when their residents are hospitalized,

- utilize our database of 2,615 potentially improper claims to determine the amount of improper Medicaid reimbursement claimed by the ALPs for their residents who were in hospitals and return the Federal share of these overpayments to the Federal Government, and

- reinforce its guidance to ALP providers that State regulations prohibit claims for their residents who are hospitalized.

STATE'S COMMENTS

In its January 10, 2006 written response to our draft audit report, the State disagreed with our findings and two of our three recommendations. State officials contend that edits were in place and working to prevent claims made by both ALPs and inpatient hospitals on the same date of service for the same ALP beneficiary, and disagreed that ALP providers did not always follow State regulations that prohibited claims for their residents who were hospitalized. These officials did agree to review the individual circumstances surrounding the 2,615 potentially improper claims in our database to determine if inappropriate Medicaid payments were made. State officials also provided technical comments. The State's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing the Federal Office of Management and Budget Circular No. A-87, State regulations, New York's Medicaid State plan, and the State's comments on our draft report, we continue to believe that our findings and recommendations are valid. We incorporated into this report the technical comments provided by the State.

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INTRODUCTION

BACKGROUND

Federal Medicaid Program

Pursuant to Title XIX of the Social Security Act, the Medicaid program pays the health care costs of persons who qualify because of medical condition, economic condition, or other qualifying factors. Medicaid costs are shared between the Federal Government and participating States. Within the Federal Government, the Medicaid program is administered by the Centers for Medicare & Medicaid Services (CMS).

To participate in the Medicaid program, a State must submit and receive CMS's approval of a State plan. The State plan is a comprehensive document describing the nature and scope of the State's Medicaid program and the State's obligations to the Federal Government. The Medicaid program pays for medically necessary services that are specified in Medicaid law when included in the State plan and when provided to individuals eligible under the State plan.

New York's Medicaid Program

In New York State, the Department of Health is the State agency responsible for operating the Medicaid program. Within the Department of Health, the Office of Medicaid Management is responsible for administering the Medicaid program. The Department of Health uses the Medicaid Management Information System (MMIS), a computerized payment and information reporting system, to process and pay Medicaid claims (the system is currently known as eMedNY).

The State's Federal medical assistance percentage was 50 percent for claims paid from January 1, 1999, through March 31, 2003, and 52.95 percent from April 1, 2003 through February 29, 2004.

New York's Assisted Living Program

New York's assisted living program was established by Chapter 165 of the Laws of 1991 to serve individuals who are medically eligible for residential health care facility (nursing home) placement, yet who are not in need of the highly structured, medical environment of a nursing home and whose needs could be met in a less restrictive and lower cost residential setting. The assisted living program meets the needs of these individuals by combining residential services of an adult home or an enriched housing program with a licensed home care services agency, a long term home health care program, or a certified home health agency for the provision of supportive home care services.

An Assisted Living Program (ALP) provides long-term residential care, room, board, housekeeping, personal care supervision, and home health services (either directly or under arrangements with other providers) to five or more adults. The State's Medicaid program

reimburses ALPs for nine services provided to Medicaid eligible residents via a per diem rate. The nine services included in the rate, for which no other Medicaid billing may occur, are: (1) personal care services, (2) home health aide services, (3) personal emergency response services, (4) nursing services, (5) physical therapy, (6) occupational therapy, (7) speech therapy, (8) medical supplies and equipment not requiring prior approval, and (9) adult day health care. During our audit period, 61 ALPs received Medicaid reimbursement for 1,954,433 claims totaling $219,977,118 ($109,961,975 Federal share).

Medicaid Coverage for Assisted Living Programs

Services provided by ALPs are covered by New York's Medicaid State plan. The Federal Office of Management and Budget Circular No. A-87 establishes principles and standards for determining allowable costs applicable to grants with State and local governments. Section C.,1.,c. of Attachment A of these principles states that in order to be allowable under a grant program, costs must be authorized or not prohibited under State or local laws or regulations. State regulations at NYCRR, Title 18, section 505.35 were promulgated to govern services provided by ALPs. Section 505.35(7) of these regulations states that the Medicaid program will not make payments for assisted living program services provided to a Medicaid recipient while the recipient is receiving residential health care facility (nursing home) services or inpatient hospital services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether ALPs within the State were improperly claiming Medicaid reimbursement when their residents were in hospitals or nursing homes.

Scope

Our audit period covered January 1, 1999 through February 29, 2004. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we reviewed internal controls that were significant to the objective of our audit.

We performed fieldwork at the State Department of Health in Albany, NY, and at the State's MMIS fiscal agent in Menands and Rensselaer, NY.

Methodology

To accomplish our objective, we:

- held discussions with CMS officials to determine the applicable Federal and State regulations and guidelines governing assisted living program services;

- obtained and reviewed Federal and State laws, regulations, and guidance applicable to assisted living facilities;

- held discussions with State officials related to the objective of our audit;

- reviewed MMIS edit documentation provided by State officials related to ALPs;

- performed survey site visits to six ALPs;

- ran computer programming applications at the MMIS fiscal agent that identified 1,954,433 claims from 61 ALPs totaling $219,977,118 ($109,961,975 Federal share).

- matched the ALPs' claims against the inpatient hospital and nursing home files at the MMIS fiscal agent which resulted in 7,247 ALP residents' claims from 59 ALP providers matching 5,380 inpatient hospital and nursing home claims;

- analyzed the matches and eliminated 4,632 ALP claims that appeared appropriately billed (mainly because they were either day of admission or day of discharge claims) resulting in a revised universe of 2,615 claims made by 53 ALPs totaling $277,363 ($140,479 Federal Share) for review (the 2,615 claims only matched inpatient hospital claims, not nursing home claims);

- used simple random sampling techniques to select a sample of 30 claims to validate that all 2,615 ALP claims were improperly claimed for Medicaid reimbursement when ALP residents were in hospitals;

- requested supporting documentation from the ALPs and the inpatient hospitals for the 30 sampled claims; and

- reviewed the supporting documentation for the 30 sampled claims to determine if the ALPs improperly claimed Medicaid reimbursement for their residents who were in hospitals.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

ALPs improperly claimed Medicaid reimbursement for their residents who were in hospitals, but not in nursing homes. In our opinion, these unallowable claims occurred because: (1) the State did not have edits and controls in their MMIS to detect claims made by both an ALP and an inpatient hospital on the same date of service for the same beneficiary, and (2) ALP providers did not always follow State regulations that prohibited claims for their residents who were hospitalized.

ASSISTED LIVING PROGRAMS' IMPROPER CLAIMS

As described in the "Methodology" section of this report, we identified a universe of 2,615 claims made by 53 ALP providers that we believed were improperly claimed for Medicaid reimbursement. Appendix A of our report provides a listing of the 2,615 claims by ALP. To validate our belief, we selected a random sample of 30 claims for review. Twenty-nine of the 30 claims were improperly made for ALP residents who were in hospitals. The 29 improper ALP claims totaled $4,220 ($2,132 Federal share). For one sampled claim, a hospital incorrectly billed Medicaid using a wrong ALP beneficiary's Medicaid identification number. While the hospital claim was in error, the ALP sample claim was valid. Because all 30 sampled claims were not in error, we did not compute the overpayment amount of our universe.

CAUSES OF THE UNALLOWABLE CLAIMS

As discussed below, we found two main causes of the unallowable claims.

No State Controls

The State did not have edits and controls in its MMIS to detect claims made by both an ALP and an inpatient hospital on the same date of service for the same beneficiary during our audit period.

Failure to Follow State Regulations

ALP providers did not always follow State regulations found at NYCRR, Title 18, section 505.35(7) that states that the Medicaid program will not make payments for assisted living program services provided to a Medicaid recipient while the recipient is receiving residential health care facility (nursing home) services or inpatient hospital services.

RECOMMENDATIONS

We recommend that the State:

- institute eMedNY edits and ensure that they are effective to prevent ALPs from claiming and receiving Medicaid reimbursement when their residents are hospitalized,

- utilize our database of 2,615 potentially improper claims to determine the amount of improper Medicaid reimbursement claimed by the ALPs for their residents who were in hospitals and return the Federal share of these overpayments to the Federal Government, and

- reinforce its guidance to ALP providers that State regulations prohibit claims for their residents who are hospitalized.

STATE'S COMMENTS

In its January 10, 2006 written response to our draft audit report, State officials disagreed with our findings and two of our three recommendations. State officials also provided technical comments.

The State contended that controls and edits were in place and working in MMIS/eMedNY to prevent claims made by both ALPs and inpatient hospitals on the same date of service for the same ALP beneficiary through the Principal Provider Subsystem entry. However, they agreed to review and assess the possibility of strengthening the existing edits. Additionally, the State noted that it periodically completes post payment matches to identify duplication between inpatient hospital and nursing home claims.

State officials also disagreed that ALP providers failed to follow State regulations that prohibited claims for their residents who were hospitalized, and that guidance should be reinforced. According to the State, the contract between the ALP and the local social services district specifies that the ALP must immediately notify the local district when any of their Medicaid residents enters a hospital to receive inpatient care.

The State did agree to review the individual circumstances surrounding the 2,615 potentially improper claims in our database to determine if inappropriate Medicaid payments were made. State officials requested that we provide them with this database.

State officials provided some technical comments. They requested that our report refer to the providers as Assisted Living Programs rather than Assisted Living Facilities. They also asked that we detail the nine specific services provided to Medicaid eligible residents via an ALPs per diem rate (also referred to as a capitated rate by the State).

The State's comments are included in their entirety as Appendix B.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

The State contended that controls and edits were in place and working in its MMIS/eMedNY. We found no evidence of these controls and edits during our review. We also identified a database of 2,615 potentially improper claims, and found that 29 of the 30 claims in our sample were improperly made for ALP residents who were in hospitals during our review period.

When we further questioned State officials about the computer edits after receiving their comments, we obtained as clarification an eMedNY project request for cross-invoice edits for inpatient and ALP claims. This request was dated January 10, 2006, the same day as the State comments to our draft report. The request indicates that eMedNY did not have edits to detect claims made by both an ALP and an inpatient hospital on the same date of service for the same beneficiary. This eMedNY Project Request #0939 document is included in its entirety as Appendix C.

Additionally, we continue to believe that ALP providers did not always follow State regulations that prohibited claims for their residents who were hospitalized during our audit period. Further, although we recommended that the State reinforce its guidance to ALP providers, the State only commented on existing contract provisions. We believe further reinforcement is necessary.

In regards to our database of 2,615 potentially improper payments, we will provide the State with the requested detailed claims information needed to complete their review to determine if inappropriate Medicaid payments were made.

We incorporated into this report the technical comments made by the State.

APPENDIXES

List of Potentially Improper ALP Claims
January 1, 1999 Through February 29, 2004

ALP Name	No. of Improper Claims	Medicaid Amount Overpaid	Federal Share Amount Overpaid
THE FALLS	79	$ 10,784.80	$ 5,511.09
NORTHBROOK HEIGHTS	1	53.12	26.56
HOME SWEET HOME OF ATHENS	10	1,482.62	758.29
HILLCREST SPRING	63	10,385.34	5,224.58
VILLAGE VIEW	77	4,199.62	2,162.56
GOLDEN CARE	55	3,484.69	1,775.60
DANFORTH ADULT CARE CENTER	11	2,009.32	1,006.55
THE SHIRE AT CULVERTON	38	3,853.64	1,959.59
ROBYNWOOD	22	3,419.79	1,711.62
TIOGA HEALTH CARE FACILITY	5	493.29	248.43
DUTCHESS CARE	23	1,031.67	515.84
MCAULEY LIVING SERVICES	1	153.86	81.47
MENORAH CAMPUS	5	1,565.53	784.02
BRIARWOOD MANOR	3	133.53	69.50
ANNA ERIKA	512	34,899.27	17,834.29
LORETTO REST	62	14,718.80	7,406.32
CHURCHILL MANOR	19	3,951.59	1,980.13
PRESBYTERIAN RESIDENCE COMMUNITY	5	540.69	276.58
BUCKLEY LANDING	37	6,500.71	3,286.17
LORETTO AT JAMES GEDDES	7	1,317.08	658.54
EPISCOPAL CHURCH HOME	10	2,601.58	1,300.79
NEW CENTRAL MANOR	28	2,299.95	1,156.89
MADISON YORK	152	10,689.42	5,379.63
ELM YORK	61	4,031.59	2,034.98
THE WARTBURG RESIDENCE COMMUNITY	1	65.63	32.82
VASSAR WARNER HOME	6	1,108.44	562.76
THOMAS JEFFERSON	36	2,864.87	1,459.31
LONG ISLAND HEBREW LIVING CENTER	91	7,056.06	3,546.92
VALLEY VISTA	3	465.32	234.11
LORETTO UTICA CENTER	76	8,686.59	4,414.26
HILTON EAST RESIDENCE HOME	64	7,914.38	3,984.28
MT. ALVERNO	43	11,711.10	5,941.38
SENECA HEIGHTS	94	22,029.72	11,108.16
FAMILY SERVICES OF ROCHESTER	14	1,371.79	710.13
ROSEWOOD SENIOR VILLAGE	4	200.59	100.30
TANGLEWOOD MANOR	73	5,604.14	2,816.18
BROOKDALE HOSPITAL MEDICAL CENTER	54	10,880.16	5,702.78
BRONXWOOD HOME	422	27,028.77	13,663.15
IDEAL SENIOR LIVING CENTER	5	2,222.34	1,116.14
ASSISTED LIVING OF NORTH RIVER	10	2,436.41	1,224.86
MERMAID MANOR	129	9,011.40	4,519.49
SENECA TERRACE	24	2,108.32	1,056.05

ALP Name	No. of Improper Claims	Medicaid Amount Overpaid	Federal Share Amount Overpaid
EDEN PARK HEALTH SERVICES	37	8,237.19	4,143.15
PINEVIEW COMMONS HOME	11	1,373.09	705.88
MARCHAND MANOR HOME FOR ADULTS	6	626.12	320.00
DESALES RESIDENCE	81	15,025.32	7,531.09
GREEN MANOR	8	1,601.12	803.24
AVALON ASSISTED AWELL CENTER	8	433.95	227.89
NORTHBROOK HEIGHTS HOME	2	444.84	222.42
REGENCY SENIOR LIVING CENTER	19	1,454.06	760.61
KENWELL HOME FOR ADULTS	3	171.71	89.19
WOODHAVEN HOME FOR ADULTS	2	378.06	200.18
NEW BROADVIEW MANOR	3	250.38	132.58
53 ALPs	**2,615**	**$277,363.38**	**$140,479.28**

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

January 10, 2006

James P. Edert
Regional Inspector General for
Audit Services
DHHS OIG Office of Audit Services
26 Federal Plaza
Room 3900A
New York, New York 10278

Dear Mr. Edert:

Enclosed are the Department of Health's comments on the DHHS - OIG's Draft Audit Report (A-02-05-01003) on "Review of Assisted Living Facilities' Medicaid Claims When Their Residents Are in Hospitals."

Thank you for the opportunity to comment.

Sincerely,

Dennis P. Whalen
Executive Deputy Commissioner

Enclosure

cc: Mr. Dougherty
Mr. Griffin
Mr. Howe
Ms. O'Connor
Mr. Seward
Mr. Reed
Mr. Wing

Department of Health
Comments on the
Department of Health and Human Services
Office of Inspector General
Draft Audit Report A-02-05-01003 on
"Review of Assisted Living Facilities' Medicaid Claims When Their Residents Are in Hospitals"

The following are the Department of Health's (DOH) comments in response to the Department of Health and Human Services (DHHS), Office of Inspector General (OIG) draft audit report (A-02-05-01003) on "Review of Assisted Living Facilities' Medicaid Claims When Their Residents Are in Hospitals."

General Comments:

The audit report inappropriately refers to Assisted Living Programs (ALP) as Assisted Living Facilities (ALF). An ALP is a combination of a residential component (an adult home or enriched housing program) and a home care agency (a licensed home care services agency or a certified home health agency or a long term home health care program). An assisted living facility in and by itself is not a qualified provider of ALP services.

In the last sentence of the first paragraph under Background of the Executive Summary, the word "nine" should be inserted in front of "services provided to Medicaid eligible residents via a per diem rate." Consideration should be given to disclosing that those nine services that are included in the capitated rate and for which no other Medicaid billing may occur include: personal care services, home health aide services, personal emergency response services, nursing services, physical therapy, occupational therapy, speech therapy, medical supplies and equipment not requiring prior approval, and adult day health care in a program approved by the Commissioner of Health.

The last paragraph at the bottom of page 1 of the Introduction is incorrect. If the sentence is meant to depict the services an ALP can provide, then the nine services that are included in the capitated rate and referenced above should be identified. If the sentence is meant to describe the services that an enriched housing program or an adult home is responsible for providing, then the appropriate definitions within law and regulations should be consulted to obtain the correct information.

On page 3, Findings and Recommendations, (1) states "the State does not have edits and controls in their MMIS to detect claims made by both an ALF and an inpatient hospital on the same date of service for the same beneficiary and (2) ALF providers failed to follow State regulations that prohibited claims for their residents who were hospitalized." The Department disagrees with this determination. Controls and edits are operational in MMIS/eMedNY.

Recommendation #1:

Establish edits and controls in MMIS to prevent ALFs from claiming Medicaid reimbursement when their residents are hospitalized.

Response #1:

Edits are in place and working properly. Edits were incorporated into MMIS/eMedNY claims processing to prevent same day ALP and inpatient hospital billing through the use of the Principal Provider Subsystem (PPS) entry. The Department will review and assess the possibility of strengthening the existing edits.

In addition, the Office of Medicaid Management periodically completes post payment matches to identify duplication between inpatient hospital and nursing home claims.

Recommendation #2:

Utilize our database of 2,615 potentially improper claims to determine the amount of improper Medicaid reimbursement claimed by the ALF for their residents who were in hospitals and return the Federal share of these overpayments to the Federal Government.

Response #2:

To determine if there were improper payments, the Department will have to review the individual circumstances surrounding the claims in question to determine if inappropriate payments were made to the hospital or the ALP. Please provide the detailed claims for the 2,615 potentially improper claims to complete this review.

Recommendation #3:

Reinforce guidance to ALF providers that State regulations prohibit claims for their residents who are hospitalized.

Response #3:

The ALP contract between the local districts and providers states in Section 2, Assisted Living Program Services, "The provider is responsible for assuring that the social services district is immediately notified when any Medicaid Assistance recipient to whom ALP services has been furnished enters a hospital to receive in-patient care..." The controls and edits in place to avoid inappropriate payments are explained in Response #1.

eMedNY Project Request

Release Priority: Medium

Project #0939

Date Originated: 1/10/2006

Create Cross-Invoice Edits for Inpatient and ALP Claims

Description: A recent audit by the DHHS-OIG of New York State's Medicaid Program identified Assisted Living Plans (ALP's) that were improperly claiming Medicaid reimbursement when their residents were in inpatient hospitals. Potentially inappropriate claims totalled approximately $300,000. These claims were paid because the State does not have edits in eMedNy to detect claims made by both an ALP and an inpatient hospital on the same date of service for the same beneficiary. We would like to create two crossover edits that would correct this problem. First, we would like an edit that would deny an ALP claim if a similar inpatient claim is in history. We would also like an edit that would identify an ALP claim if it is in history (paid first), but pay the inpatient claim.

Origination: Phase II Evolution

Originator: Medak, Sal (State - Fraud Cntrl/Prog Intgrty)

Function Code: 058 - Claims

Project Coordinator:

State Contact: Donnelly, James

Status/Disposition

Phase II Evolution - Systems Development

Decision: Open

Decision Date:

Outcome: To be Determined

Proposed Implementation Date:

Scope: Out

Scope Date: 1/10/2006

Release Date:

ROM: 0

Comments:

Transmittal References

Transmittal #	Date	Type	Additional Info.
H04234	1/10/2006	Initial Request	

ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Edert, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

John Berbach, *Audit Manager*
Kevin Smith, *Senior Auditor*
Nicholas Halko, *Auditor*
Stephen Bugler, *Auditor*

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