



OFFICE of INSPECTOR GENERAL
NATIONAL RAILROAD PASSENGER CORPORATION

GOVERNANCE:

Opportunities to Improve Controls over Medical Claim
Payments

OIG-A-2018-005 | March 14, 2018

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Memorandum

To: DJ Stadler
Executive Vice President/Chief Administration Officer

From: Stephen Lord 
Assistant Inspector General, Audits

Date: March 14, 2018

Subject: *Governance: Opportunities to Improve Controls over Medical Claim Payments*
(OIG-A-2018-005)

From calendar years 2013 through 2015, Amtrak (the company) paid about \$692 million in medical costs under the Group Health Plan for agreement employees (the plan) from its operating budget. This included \$167 million (about 24 percent) in claims paid to about 151,000 *individual* medical service providers, such as physicians, nurses, and physical therapists—as well as \$525 million in claims paid to hospitals and other medical providers, such as laboratories and home health care agencies. These providers submitted medical claims on behalf of active and retired agreement (union) employees and their dependents.¹ The company outsources the administration of the plan, including the adjudication of these medical claim payments by contracting with external claim administrators. The Benefits group within the Human Resources (HR) department oversees the administrators' activities.

The Federal Bureau of Investigation (FBI) estimates that 3 to 10 percent of all health care expenditures are fraudulent. In July 2017, the Departments of Justice and Health and Human Services (HHS) led a nationwide sweep that resulted in criminal and civil charges against 412 individuals—including 115 doctors, nurses, and other medical providers—for their alleged participation in health care fraud schemes involving approximately \$1.3 billion in false billings. Those arrested included a licensed acupuncturist providing services to company employees who was charged with eight counts of health care fraud and three counts of money laundering.

Our objective for this report was to identify the extent to which the company's controls mitigate the risk of fraud in claims for medical services made by individual medical

¹ This includes about 46,000 people. The terms and conditions of employment for agreement employees are covered by collective bargaining agreements.

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service providers, such as physicians, nurses, and physical therapists. Using our data analytics capabilities, we identified suspicious billing patterns. We focused on medical claims submitted on behalf of agreement employees and their dependents because of their high aggregate value compared to those of management employees. To assess the company's controls over medical payments, we used private- and public-sector management control standards and other leading practices. For additional details on our scope and methodology, see Appendix A.

SUMMARY OF RESULTS

The company has opportunities to improve its controls for mitigating the risk of fraud in claims for medical services. We found that the company appears to be identifying only a small portion of potentially fraudulent medical claims made by individual medical service providers. For example, the company's primary claim administrator (contractor) identified less than one percent of the claims it processed from 2013 through 2015 as fraudulent. In contrast, we found that about 14 percent of the medical claims we examined for the same period had billing patterns indicative of potential fraud. Specifically, we identified 504 providers with billing patterns indicative of potential fraud, and we are questioning whether the \$23.4 million in medical claims the company paid to these providers was proper.²

We also found that the company's contracts with the claim administrators do not include key fraud prevention practices used in the private- and public-sector. For example:

- Contracts with the claim administrators do not have fully developed fraud prevention requirements, including "performance guarantees" to help ensure that the contractor performs its key obligations at or above the established threshold under the contract.
- The HR Benefits group does not systematically assess the effectiveness of the fraud prevention and detection controls of its claim administrators to identify potential gaps.
- The HR Benefits group does not independently analyze its medical claims data for trends, patterns, and indicators of potentially fraudulent schemes.

² In conducting our work, we did not review employees' medical files, interview employees, or visit employees' medical providers; thus, we recognize that some of the claims could be appropriate.

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To help strengthen the company's controls and reduce the risk of fraudulent medical payments, we recommend that the company document and implement a plan to address the vulnerabilities we identified using the leading practices discussed in this report, such as including performance guarantees in contracts with claim administrators, systematically assessing the effectiveness of administrators' fraud prevention and detection controls, and independently analyzing medical claims data to identify potential fraud. Such a plan should be based on an analysis of spending priorities, and—consistent with generally accepted program management principles—commit needed staff and resources, assign clear roles and responsibilities, and establish monitoring requirements and performance metrics to assess progress.

We also recommend that the company consider:

- reviewing the medical providers' claims we identified as at risk for potential fraud; and
- seeking recovery of the \$23.4 million in potential improper payments identified in this report.

In commenting on draft of this report, the company's Vice President of Human Resources agreed with our recommendations to develop and implement a plan to regularly assess and address vulnerabilities in the company's health care plan. As part of this effort, the company agreed to consider adding or customizing controls and performance guarantees in claim administrators' contracts to mitigate the risk of fraud and abuse. Management also agreed to consider reviewing potentially fraudulent claim activities of the medical providers we identified, and to seek recovery of the \$23.4 million in potential improper payments.

BACKGROUND

The company paid about \$692 million in medical claims submitted under the plan on behalf of active and retired agreement employees and dependents from calendar years 2013 through 2015. Aetna, the company's primary claim administrator (contractor), processed about 97 percent of the claims—about \$674 million. Another contractor, Total Health Plan (Tufts), administered the remaining 3 percent of the claims paid for employees who lived in Massachusetts—about \$18 million. Table 1 shows the medical claims paid by each claim administrator on behalf of the company from calendar years 2013 through 2015.

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**Table 1. Claim Payments by Third-Party Claim Administrators,
 2013 through 2015
 (dollars in millions)**

Claim Administrator	Total Claims Paid	To Individual Medical Service Providers	To Hospitals and Other Facilities
Aetna	\$ 674	\$ 161	\$ 513
Tufts	\$ 18	\$ 6	\$ 12
Total	\$ 692	\$ 167	\$ 525

Source: OIG analysis of Amtrak health care medical claims data

Aetna provides employees with access to a network of medical service providers with whom it has negotiated contract rates for medical procedures. Employees can seek medical services from these in-network providers, or they can go to out-of-network providers but pay more for each service.

- **In-network providers** are limited to charging contract rates for medical procedures. These providers generally collect a co-payment³ from the employee and submit a claim for the remaining bill amount to the claim administrator. Although the plan pays in-network providers' claims at their contract rates, these rates can vary significantly among providers based on location, demand, and providers' reputations. Typically, the plan pays 100 percent of in-network provider's claims.
- **Out-of-network providers** are limited to charging "reasonable and customary" rates for medical procedures within a geographic region. Aetna determines reasonable and customary charges using an index that is commonly used across the health care industry to identify reasonable charges for different areas. Employees are responsible for 100 percent of the claim amount until they meet an annual deductible.⁴ The plan then pays 75 to 85 percent of the claims,⁵ and the employee pays the remainder until the employee meets an annual out-of-pocket

³ Co-payments vary depending on the medical service.

⁴ From calendar years 2013 through 2015, the deductibles ranged from \$100 to \$300 per person and from \$300 to \$900 per family, depending on the type of coverage the employee has selected.

⁵ The plans paid up to 100 percent of reasonable and customary charges for preventive care.

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maximum.⁶ Once the employee meets the annual maximum, the plan pays 100 percent of out-of-network providers' claims.

Aetna processes the claims that medical service providers submit on behalf of the company's active and retired agreement employees, and their dependents, and pays the plan's share using the company's funds. These claims typically include the provider's name and identification number, the patient's name, the service location, the date of service, a diagnosis code, a medical procedure code, and the billed amount. Aetna uses this information to ensure that medical claims are submitted for the covered procedures in accordance with the rules established in the company's medical plan and are paid to the appropriate provider.

WEAK MEDICAL PLAN CONTROLS PUT COMPANY FUNDS AT RISK

The company has weak controls for preventing and detecting potential fraud in medical claims payments made to individual medical service providers when compared to private and public fraud-prevention standards. In addition, our analysis of providers' billing activities indicates greater potential for fraud in these medical claims than the company's contractors are identifying.

Controls to Prevent and Detect Potential Fraud Are Weak

The company relies primarily on the efforts of its claim administrators (contractors) to prevent and detect potential fraud in medical claim payments. These claim administrators have investigative units to identify potential fraud for their clients, and Aetna and Tufts officials told us that they work with law enforcement agencies—primarily the FBI and state regulatory agencies—to take action to recover funds and pursue litigation when inappropriate billing is confirmed. Aetna officials also told us that, from calendar years 2013 through 2015, Aetna prevented \$1.9 million in fraudulent claims against the company's medical plan before the claims were paid—less than one percent of the total amount of claims the company paid during this period. During the same period, Aetna reported recovering about \$11,000, and Tufts reported recovering \$29,000.

However, our analysis indicates a greater potential for fraud than claim administrators are identifying. As a self-insured company, Amtrak bears the risk of improper payments resulting from potential fraud, but its contracts with its claim administrators

⁶ From calendar years 2013 through 2015, the annual overall out-of-pocket maximum ranged from \$1,500 to \$2,000 per person and from \$3,000 to \$4,000 per family, depending on the type of coverage.

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do not have clear and measurable requirements or effective performance guarantees to prevent and detect fraud, which is not consistent with leading practices in the private and public sectors. A performance guarantee helps ensure that the contractor provides superior performance on some of its key obligations at or above the established threshold under the contract. Failing to meet the performance guarantee will result in a financial penalty for the contractor. Without more specific fraud controls and performance guarantees, the company cannot assess the effectiveness of its claims administrators' efforts to prevent and detect fraud. Specifically:

- **Aetna.** The company's contract with Aetna contains no performance guarantees aimed at preventing and detecting fraud. Instead, the company relies entirely on the standard fraud controls that Aetna provides to all of its clients, rather than contractually requiring it to design and implement fraud controls specifically tailored to the provisions of the company's medical plan—such as controls designed to detect unusual payments activities in specific medical specialties or geographic regions. An Aetna official told us that Aetna does not tailor its fraud prevention controls for specific clients.⁷
- **Tufts.** The company's contract with Tufts includes an incentive that allows Tufts to earn 25 percent of any recoveries made from fraud detection, but as noted above, Tufts recovered only \$29,000 in fraudulent payments from calendar years 2013 through 2015. Additionally, like Aetna, the company has not required Tufts to develop fraud controls specific to the company's medical plan and relies entirely on the fraud controls that Tufts provides to all of its clients.

For the contract clauses relevant to preventing and detecting fraud in medical claims, see Appendix C.

Further, under the terms of its contract, the administrators are required to notify our office of any potentially fraudulent activities they identify, including overpayments, duplicate billings, and trends; however, the contract does not specify how frequently they are required to notify us. An Aetna official stated that, from 2013 through 2015, Aetna referred 11 cases of potential fraud to our office. Once our audit was underway, Aetna's referrals increased to 183 cases from January 2016 to July 2017. Tufts has not notified any fraud to our office since 2013.

⁷ Additionally, an official from United Healthcare (the company's former claims administrator) told us that they do not tailor their fraud prevention controls for specific clients.

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The HR Benefits group is responsible for establishing effective internal controls and mitigating the risk of potential fraud in medical claim payments; however, it has not separately assessed this risk in accordance with fraud prevention leading practices. In particular:

- **The HR Benefits group has not assessed the effectiveness of Aetna’s controls.** In 2015 and 2016, the HR department designated the risk of fraudulent medical payments as low in the company’s annual Fraud Risk Assessment. This assessment identifies incentives and opportunities to commit fraud against the company and helps the company determine whether controls to mitigate these risks can be improved. An HR official told us that the risk was deemed low because Aetna is responsible for preventing and detecting fraud. However, the HR Benefits group has not yet taken any steps to assess the effectiveness of Aetna’s fraud prevention and detection controls. Without assessing Aetna’s fraud controls, the HR department may not have accurately assessed its overall risk. For example, our July 2016 report identified about \$4.3 million of potential duplicate medical payments, some of which could be fraudulent.⁸ In response to our report, HR officials agreed to perform an independent review of medical claims processed by the claim administrators; however, as of December 2017, the company had not undertaken such a review.
- **The HR Benefits group is not independently analyzing its medical claims data.** HR officials told us that they have not independently analyzed the plan’s medical claims data to identify relevant trends, patterns, and indicators of potentially fraudulent schemes. Without this information, the company cannot reasonably ensure that fraud risks are being effectively mitigated. The Government Accountability Office (GAO) has reported that managers who more fully analyze their company’s medical claims data are better positioned to assess the risk of potential fraud.⁹ This analysis allows them to design effective mitigating controls and helps their companies reduce their total exposure to risk from fraud. As part of an antifraud strategy, these managers design and implement specific control activities—such as establishing effective policies, procedures, and techniques to prevent and detect potential fraud.

⁸ *Governance: Controls To Avoid Duplicate Medical Payments of Agreement Employees Appear Generally Effective, but Some Payment Errors Still Occur* (OIG-A-2016-009), July 15, 2016.

⁹ GAO, *A Framework for Managing Fraud Risks in Federal Programs* (GAO-15-593SP), July 2015.

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Further, as demonstrated by our analysis of the plan's medical claims data, which we discuss below, such an analysis could identify potential weaknesses in the contractors' controls and provide additional opportunities to identify and prevent fraud in medical payments.

Billing Patterns Appear to Indicate Potential Fraud

We identified billing patterns in providers' claims that may indicate potential fraud against the company's medical plan. Using a risk-based approach, we focused our analysis on 890 individual medical service providers—less than 1 percent of about 151,000 individual providers—who received the highest payments from the company's medical plan (about \$32.8 million) from calendar years 2013 through 2015.¹⁰ Of these, we identified 504 providers with suspicious billing patterns.¹¹ From 2013 through 2015, the company's medical plan paid these providers \$23.4 million—about 14 percent of the \$167 million paid to individual medical service providers during that period. In June 2017, the Department of Justice charged one of these providers—who received about \$1.2 million in claim payments under the plan—with eight counts of health care fraud and three counts of money laundering.¹² Figure 1 shows the distribution of the 10 states with the highest concentration of the providers and their specialty areas.

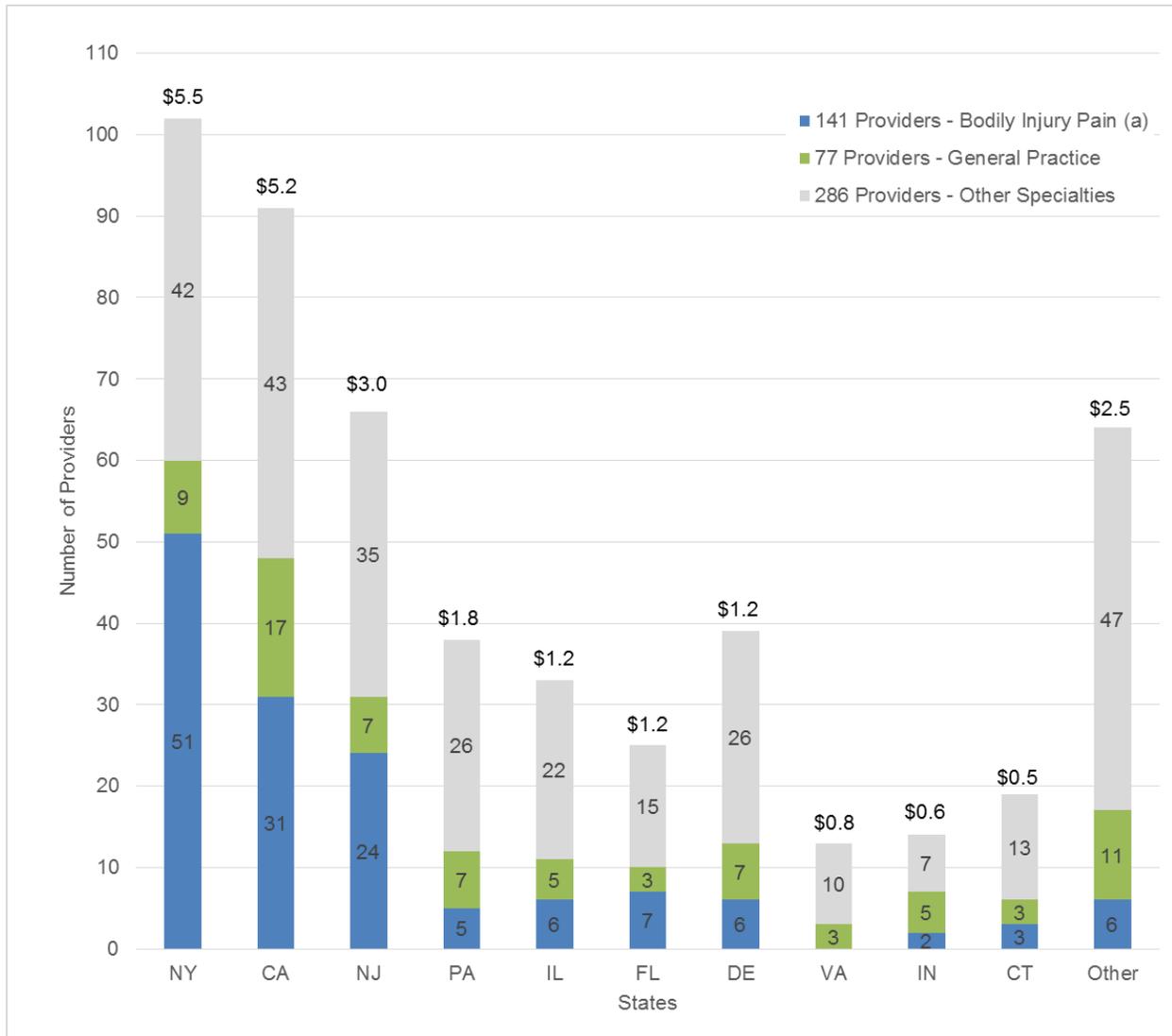
¹⁰ The \$32.8 million in medical claims payments made to these 890 providers is about 20 percent of the total amount of \$167 million in payments made to individual medical service providers from calendar years 2013 through 2015.

¹¹ Using risk indicators that we developed and corroborated with the Office of Inspector General of the U.S. Department of Health and Human Services, we compared the billing patterns of the highest paid providers to all 151,000 individual medical providers who filed claims with the company during the period. For more details on our methodology, see Appendix A.

¹² An Amtrak OIG investigation resulted in the acupuncturist being charged for health care fraud and money laundering. See *Amtrak Employee and California Health Care Providers Charged In Health Care Fraud Scheme* (Investigative Press Release), July 13, 2017.

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Figure 1. Distribution of 504 Providers—with Billing Patterns that May Indicate Potential Fraud—by State and Specialty from 2013 through 2015 (dollars in millions)



Source: OIG analysis of Amtrak health care medical claims data

Note:

^(a) Bodily injury pain specialists include podiatrists, acupuncturists, chiropractors, physical therapists, and orthopedic surgeons.

As shown in Figure 1 above, the 504 providers were generally concentrated in several key specialties that employees commonly use given the physical nature of their work and in some geographical areas where the company has significant business operations. Of these providers, 141 (28 percent) were bodily injury pain specialists, such as podiatrists, acupuncturists, chiropractors, physical therapists, and orthopedic surgeons.

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We are not questioning employees' use of bodily pain specialists, but this group of 141 providers had a larger representation of suspicious billing patterns in our analysis than other bodily injury pain specialists. Another 77 of the 504 providers were general practitioners (about 15 percent).

We discuss below some of the key indicators we identified and examples of potential fraud that could have resulted in improper payments. For a more detailed discussion see Appendix B.

High prices can indicate that medical service providers may have overcharged for the services or supplies rendered. Our analysis shows that 264 of the 504 providers charged significantly higher prices than other providers. Together, these 264 providers charged about \$5.3 million more than the average charged by all providers for the same procedures.

Most of these providers were out of network, accounting for \$4.7 million or 89 percent of the price difference. Although in-network and out-of-network providers can charge high prices for some types of services, out-of-network providers have a greater opportunity to do so because the company allows these providers to charge reasonable and customary rates for their services instead of contracted rates, which gives these providers greater flexibility in the rates they charge. Additionally, an Aetna official told us that the reasonable and customary rates under the Amtrak plan were higher than the rates allowed for other plans that Aetna administers, which encourages out-of-network providers to bill higher prices to the Amtrak plan (impacting both the plan and participants covered under the plan).¹³ Further, company officials told us that the generous benefits provisions relative to out-of-network claims under the plan likely presents challenges in limiting employees from using out-of-network providers, which adds to the cost of the program.¹⁴

Some examples of high prices we identified include the following:

- A podiatrist charged about \$190 for 15-minute patient office visits, compared with an average of \$59 by all providers.

¹³ The Amtrak plan defines "reasonable and customary" rates as the 90th percentile of the rates that other providers charge for any particular procedure code within a defined geographical area. An Aetna official stated that most of its other self-insured clients set their limits at the 80th percentile.

¹⁴ Medical plans covering the agreement employees and the provisions under those plans are subject to collective bargaining.

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- An acupuncturist charged \$102 for a 15-minute manual therapy session, compared with an average of \$28 by all providers.
- A general practitioner charged an average of \$563 for 60-minute new patient office visits compared with an average of \$193 by all providers. This provider also charged a 60-minute office visit code for all 11 patients, whereas other general practitioners who used this code used it only once on average.

A high frequency of certain procedures can indicate that medical service providers may have submitted claims for procedures that were not actually performed or were not medically necessary. Our analysis shows that 281 of the 504 providers submitted claims for certain medical procedures more often than other providers. Examples we identified include the following:

- A general practitioner submitted claims for 544 laboratory tests for 10 patients over the 3-year period we analyzed—an average of 54 tests and about \$8,000 per patient over this time period. The average number of claims for laboratory tests submitted by all general practitioners was fewer than five per patient over the same period. In addition, claims were submitted for the same test twice in one day for six patients—once by this provider and again by an independent laboratory or substance abuse treatment facility.
- A podiatrist submitted claims for custom shoe inserts for 121 patients averaging \$790 per set of shoe inserts. Additional claims for shoe inserts were submitted for 31 of these patients in 2 of the 3 years we analyzed, and additional claims were submitted for 9 patients in all 3 of the years we analyzed. Multiple investigations by the FBI and the Office of Inspector General of the U.S. Department of Health and Human Services (HHS OIG) identified fraud involving podiatrists prescribing custom shoe inserts that were not medically necessary or billing for inserts that were not actually provided.
- A chiropractor submitted claims for three types of chiropractic sessions nearly 700 times over the period we analyzed. Other chiropractors submitted an average of 47 claims for these treatments during the same period. According to a 2015 HHS OIG report, chiropractic services had the highest rate of improper

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payments among claims for professional medical services submitted to Medicare.¹⁵

A high number of shared patients can indicate a coordinated effort among providers to refer patients to one another for unnecessary medical services in exchange for favors or kickbacks, or could be an indicator of identity theft. Examples we identified include the following:

- Two providers submitted claims for the same pain management treatments for the same patient on the same dates at least 113 times.
- Two providers submitted claims for the same laboratory tests for the same patient on the same date at least 107 times.
- One provider submitted claims for medical services provided to 20 to 30 agreement employees on a single day at least 84 times from 2013 through 2015.

These providers may have also shared patients with providers who were not within the scope of our review. For example, a podiatrist in New York had 72 patients in common with 114 providers whose claim activities were not within the scope of our review. Therefore, there is likely some risk of potential fraud from the approximately 150,000 providers we did not include in our analysis.

During our audit, we met with HR officials to share our audit methodology and initial results, including some of the suspicious billing patterns discussed above and in Appendix B. However, these officials have not developed a plan to address the vulnerabilities we identified. Such a plan would include a business case to establish decision making and spending priorities, and—consistent with generally accepted program management principles—would commit needed staff and resources, assign clear roles and responsibilities, and establish monitoring requirements and performance metrics to assess progress. HR officials told us that they would contract with an independent healthcare audit firm to review the medical claims we identified with billing patterns indicative of potential fraud, and refer any potentially fraudulent providers to our office for investigation. HR officials also told us that they were evaluating several vendor proposals to review the plan's medical claims more broadly, and would select a vendor in early 2018.

¹⁵ *CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services* (OEI-01-14-00200), September 2015.

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CONCLUSIONS

As a self-insured company, Amtrak bears the risk of improper payments resulting from potential fraud. Our analysis of medical claims data indicates a greater risk of fraud than the amount that claim administrators are identifying. Thus, documenting and implementing a plan to strengthen controls over these claims would help reduce the risk of fraud and the company's health care costs. In developing such a plan, the company could consider incorporating the leading practices identified in this report. Given the weaknesses we found, we are questioning at least \$23.4 million paid to 504 individual medical service providers from 2013 through 2015.

RECOMMENDATIONS

To effectively assess and manage the risk of fraud in medical payments, we recommend that the Vice President of Human Resources:

1. Develop and implement a cost-effective plan to address the vulnerabilities we identified by using a business case to guide its decision making and spending priorities. In doing so, the company should consider incorporating the leading practices we discussed such as:
 - Requiring claim administrators to design and implement controls specifically tailored to detect and prevent potential fraud in the company's medical plan.
 - Including appropriate performance guarantees in claim administrators' contracts to prevent and detect fraud, as well as criteria to measure their performance.
 - Requiring regular assessments of the effectiveness of claim administrators' controls for preventing and detecting potential fraud, and implementing additional controls, as necessary, to address any identified gaps.
 - Systematically analyzing and documenting assessments of the plan's medical claims data to identify indicators of potential fraud, and use this information to implement additional fraud controls as needed.
2. Consider reviewing the claims submitted by the medical service providers we identified for risk of potential fraud, and refer any providers whose activities should be further investigated to our office.
3. Seek recovery—to the extent cost-effective and practical—of the \$23.4 million in potential improper payments identified in this report.

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MANAGEMENT COMMENTS AND OIG ANALYSIS

In commenting on a draft of this report, the Vice President of Human Resources stated that the company agreed with our three recommendations and identified planned actions and implementation dates that would address the intent of our recommendations. In addition, we updated the draft report, where appropriate, to incorporate the technical comments provided by the company. The company's planned actions are summarized below.

- **Recommendation 1.** Management agreed with our recommendation to develop and implement a cost-effective plan to address the vulnerabilities we identified based on the leading practices discussed in the report. The company stated that potential components of the plan would include (i) regular analysis of medical claims data by an independent third-party to identify control gaps and the action plans to address them, and (ii) the addition or customization of controls and performance guarantees in claim administrators' contracts to mitigate the risk of fraud and abuse in Amtrak plan.
- **Recommendation 2.** Management agreed with our recommendation to consider reviewing the claims submitted by the medical service providers we identified for risk of potential fraud, and to refer any providers whose activities should be further investigated to our office. The company stated that it will use cost-benefit analysis in considering additional review of the claims submitted by potentially fraudulent medical service providers.
- **Recommendation 3.** Management agreed with our recommendation and stated that it will seek recovery of the \$23.4 million in claims we identified in the report, or any portion thereof, that are determined to be improper payments based on the additional review discussed under Recommendation 2 above.

For management's complete response, see Appendix E.

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APPENDIX A

Scope and Methodology

This report provides information on controls over medical claim payments. The scope of our work included interviewing officials from the HR department, including HR Benefits group and working with representatives from the company's medical claim administrators to obtain and understand the data in their systems. We performed our work from September 2014 through December 2017 in Washington, D.C.

Our methodology for assessing the effectiveness of company's efforts to prevent fraudulent payments to medical service providers included comparing the company's controls with those used in the private and public sectors. This included identifying and applying standards for managing risk described in the Committee of Sponsoring Organizations of the Treadway Commission's *Internal Control–Integrated Framework*, and GAO's *Standards for Internal Control in the Federal Government*. We also compared the company's practices with GAO's framework for managing fraud risks in federal programs.

Our methodology for determining whether there were potential fraudulent payments included using a specialized data-analytics tool to test the medical claim payments data obtained from the following medical claim administrators:

- Aetna from calendar years 2013 through 2015
- Total Health Plan (Tufts) for medical claims paid for employees in Massachusetts from calendar years 2013 through 2015

We took a risk-based approach in our analysis, focusing on the claim activity of the top 1 percent of individual medical service providers—890 out of about 151,000—given the financial risk associated with their claims. Our analysis of the medical claims paid under the plan showed that this group received a significant portion of the total claims paid to individual medical service providers—\$32.8 million (almost one-fifth of \$167.2 million). Payments to these 890 providers ranged from \$13,733 to \$1.2 million individually.

To identify potential fraud, we assessed their claim activity across 12 risk indicators, each focusing on identifying an anomaly in the aggregate claims they submitted. Specifically, we compared the billing patterns of the 890 highest paid providers with all 151,000 individual medical service providers who filed claims with the company during

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this period. We scored risk across each of the following 12 indicators and aggregated their scores to identify providers with suspicious billing patterns:

- One indicator compared the procedure code average pricing charged by each provider with the average charged by all providers who billed the procedure. Providers with significantly higher than average prices were flagged.
- Four indicators compared the diagnosis code average billings, average number of units billed per procedure, aggregate transaction volume per procedure, and average transaction volume for each procedure per patient by each provider against the averages by providers in the same specialty. Providers whose claims activities were significantly higher than the average were flagged.
- Four indicators focused on other billing trends in the providers' claims, such as the number of new patients enrolled, patients with high number of visits, claims without co-payments, and a consistently high volume of transactions and payments in three years. Providers with the highest numbers in these indicators were flagged.
- Three indicators identified the top billers by amount, transaction volume, and average payment per transaction. The top 100 providers in these indicators were flagged because of their financial exposure for the company.

Our approach to identify potential fraud was conservative—we only selected providers who had been flagged by two or more indicators in our analysis. We validated the reasonability of our approach for identifying fraud risk with the Director of Advanced Audit Techniques at HHS OIG, which performs similar reviews of its Medicaid, Medicare, and Children's Health Insurance programs. They are considered to be expert in this area.

In conducting our work, we did not review employees' medical files, interview employees, or visit employees' medical providers; thus, we recognize that some of the claims could be appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, 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 objective.

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Internal Controls

We focused our control work on identifying the procedures the company used to manage the risk of fraud in medical claim payments. To evaluate the company's internal controls, we compared its practices with best practices and standards used in the private and public sectors described above. We did not review the entire system of controls that ensures that claims submitted by the medical providers were appropriate and in compliance with the company's medical plan.

Computer-Processed Data

To achieve our objective, we relied on computer-processed data from the administrators' claim adjudication systems. We validated the completeness of the data we analyzed as follows. For medical claims paid from calendar years 2013 through 2015, we compared the administrators' payment records with the company's financial records and found that total payments reconciled with 98.10 percent accuracy. We also compared the total claim payment amounts in the administrators' data to the claim payment amount provided by Verisk, the contractor who collects and consolidates health care data from all administrators. We found that the total amount matched with 99.38 percent accuracy.

Based on these tests, we determined that the discrepancies between the data sets were negligible and that the data were sufficiently reliable for meeting our objectives.

Prior Audit Reports

The following reports were relevant to our work:

- *Governance: Controls to Avoid Duplicate Medical Payments of Agreement Employees Appear Generally Effective, but Some Payment Errors Still Occur* (OIG-A-2016-009), July 15, 2016
- *CMS Should Use Targeted Tactics to Curb Questionable and Inappropriate Payments for Chiropractic Services* (OEI-01-14-00200), September 2015
- *Questionable Billing for Medicare Electrodiagnostic Tests* (OEI-04-12-00420), April 2014
- *The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program, Annual Report for Fiscal Year 2016*, January 2017

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APPENDIX B

Examples of Potential Fraud by Individual Medical Service Providers

We identified billing patterns that may indicate potential fraud in the claims of some of the highest paid individual medical service providers we examined in detail, particularly for out-of-network providers.

Example 1: New York City Area Podiatrist

The company's total payments to an out-of-network podiatrist were comparatively high relative to other podiatrists. This podiatrist also had an unusually high number of transactions and patients compared to other providers in the same specialty.

Table 2 compares this podiatrist's total claim activity with the average claim activity of all 2,713 podiatrists who submitted claims to the company from calendar years 2013 through 2015.

Table 2. Example of a New York City Area Podiatrist's Claim Activity, 2013–2015

This Provider's Claim Activity		Average Claim Activity of all 2,713 Podiatrists
Payments	\$ 541,329	\$ 1,469
Number of Transactions	1,806	15
Number of Patients ^a	129	2
Number of New Patients ^b	77	1

Source: OIG analysis of Amtrak health care medical claims data

Notes:

^a Patients here refers to Amtrak plan participants and their dependents.

^b A new patient's first visit to a medical service provider is generally paid at a higher rate than follow-up visits for established patients.

In addition, we identified the following multiple risk indicators in this podiatrist's billings that may indicate potential fraud:

High prices for each procedure. This provider's charges were more than double the average prices charged by all providers for 24 of the 32 procedures billed. For example, this provider charged the following:

- about \$226 for new patient visits, compared to an average of \$94

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- about \$190 for established (15-minute) patient visits, compared to an average of \$59
- about \$173 per x-ray, compared to an average of \$44
- about \$790 per set of custom shoe inserts, compared to an average of \$467

If the provider was paid the average amount for all of the higher-priced procedures, the company would have saved about \$316,000 from this provider's billing (about 58 percent).

High frequency of certain procedures. This podiatrist submitted a high number of claims for x-rays and custom shoe inserts. The provider submitted about \$33,000 in claims for x-rays for 83 patients, and \$159,000 in claims for custom shoe inserts for 121 patients—81 patients received shoe inserts in one year, 31 received them in two years, and 9 received them in all 3 years we analyzed. This podiatrist billed about \$159,000 for custom shoe inserts, compared to an average of \$750 by the other 532 podiatrists who charged for this particular code.

Multiple HHS OIG investigations identified fraud where providers prescribed custom shoe inserts to patients that were not medically necessary, or they billed for custom shoe inserts that were not provided to patients. For example, in April 2016, a podiatrist was convicted of falsely claiming that the provider performed more expensive procedures than were actually performed or that the routine foot care was justified because of illnesses or symptoms that were not present.¹⁶

High number of shared patients. This podiatrist submitted claims for 129 patients—many more than the average of 2 patients claimed by other podiatrists. Further, this podiatrist had 95 patients in common with 140 other injury pain specialists located mostly in or around the New York City area, and 21 of them were among the 504 we identified who had other suspicious billing patterns.¹⁷ In prior work, HHS OIG found that patient-sharing among participating networks of health care providers is an indicator of potential fraud.¹⁸

¹⁶ *Annual Report of the Departments of Health and Human Services and Justice, Health Care Fraud and Abuse Control Program, FY 2016.*

¹⁷ 15 of the 21 providers connected to this podiatrist appear to be part of an additional nexus of shared patients, with 101 patients in common.

¹⁸ *Questionable Billing for Medicare Electrodiagnostic Tests (OEI-04-12-00420), April 2014.*

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The following billing patterns may indicate a nexus of potential fraud involving this podiatrist and other providers:

- Two providers submitted claims for the same service for the same patient on at least 113 dates. For example, a chiropractor and a physical therapist billed for the same services, such as unattended electric stimulation therapy, provided to the same patient on the same date, which can be an indication of potential fraud.
- This podiatrist had 64 patients in common with 2 other providers who were also among the 504 providers we identified with other suspicious billing patterns. They appear to operate from the same location; together, they submitted \$1.1 million in medical claims in the three years we analyzed.

Example 2: Los Angeles Area General Practitioner

The company's total payments to an out-of-network general practitioner were comparatively high relative to other general practitioners. The general practitioner also had an unusually high number of transactions and patients compared to other providers in the same specialty.

Table 3 compares this general practitioner's total claim activity with the average claim activity of all 32,672 general practitioners who submitted claims to the company from calendar years 2013 through 2015.

Table 3. Example of a Los Angeles Area General Practitioner's Claim Activity, 2013–2015

This Provider's Claim Activity		Average Claim Activity of all 32,672 General Practitioners
Payments	\$ 242,621	\$ 956
Number of Transactions	3,504	12
Number of Patients	79	2
Number of New Patients	11	0.36

Source: OIG analysis of Amtrak health care medical claims data

In addition, we identified the following multiple risk indicators in this general practitioner's billings that may indicate potential fraud:

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High prices for each procedure. This provider's charges were more than double the average prices charged by all providers for 66 of the 163 procedures billed. For example, this provider charged comprehensive metabolic panel tests at \$138 per test—significantly higher than the average cost of \$20 for this procedure. If the provider was paid the average amount for all of the higher-priced procedures, the company would have saved about \$110,000 from this provider's billing (about 45 percent).

High frequency of certain procedures. The general practitioner submitted a higher number of claims for certain procedures than other general practitioners, including the following:

- a total of 1,811 laboratory tests for 65 patients—an average of 28 tests per patient over a 3-year period—whereas the average number of tests submitted by all general practitioners was fewer than 5 per patient over the same period
- an average of more than 5 office visits that were after-hours and on weekends for 74 of 79 patients, whereas other general practitioners submitted claims for fewer than 2 such visits per patient (Providers can charge higher rates for after-hours visits. The company's plan paid about \$41,000 to this provider for these visits.)

High number of shared patients. This general practitioner submitted claims for 79 patients—many more than the average of 2 patients claimed by other general practitioners. Further, this provider had many patients in common with other providers, including the following:

- 44 patients in common with 16 other providers who were among the 504 we identified with other suspicious billing patterns (The 16 providers included 6 chiropractors, 5 general practitioners, 1 acupuncturist, and 1 physical therapist.)
- 31 patients in common with the acupuncturist described in the next example

Example 3: Riverside and Los Angeles Area Acupuncturist

An out-of-network acupuncturist had the highest number of patients and submitted the highest number of claims of all 151,000 individual medical service providers we reviewed.

Table 4 compares this acupuncturist's total claim activity with the average claim activity of all 230 acupuncturists who submitted claims to the company from calendar years 2013 through 2015.

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**Table 4. Example of a California Acupuncturist's
 Claim Activity, 2013–2015**

This Provider's Claim Activity		Average Claim Activity of all 230 Acupuncturists
Payments	\$ 1,234,232	\$ 11,308
Number of Transactions	30,979	207
Number of Patients	609	5
Number of New Patients	272	2

Source: OIG analysis of Amtrak health care medical claims data

In addition, we identified the following multiple risk indicators in this acupuncturist's billing that may indicate potential fraud:

High frequency of certain procedures. This acupuncturist submitted a higher number of claims for certain procedures than other acupuncturists. For example, this provider submitted claims for more than 13,000 acupuncture treatments, whereas similar treatments by other acupuncturists averaged about 208 for the same period. In all, this provider submitted claims for 869 days—about 93 percent of the total 939 working days¹⁹ from calendar years 2013 through 2015. According to these claims, the acupuncturist treated at least one Amtrak patient almost every day. For 84 of these days, these claims show that 20 to 30 patients visited this provider on each of these days.

High number of shared patients. This acupuncturist submitted claims for 609 patients—many more than the average of 5 patients claimed by other acupuncturists. Further, this provider had at least 76 patients in common with another acupuncturist, 2 chiropractors, and a general practitioner. The records show that these providers frequently submitted claims for medical services rendered to many of the 76 patients they shared in common.

On June 22, 2017, this acupuncturist was charged with eight counts of health care fraud and three counts of money laundering.²⁰ The charges arose from a number of

¹⁹ This provider had a six-day working week.

²⁰ An Amtrak OIG investigation resulted in the acupuncturist being charged for health care fraud and money laundering. See *Amtrak Employee and California Health Care Providers Charged In Health Care Fraud Scheme* (Investigative Press Release), July 13, 2017.

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allegations, including the allegation that the acupuncturist recruited Amtrak employees and then billed the company's health care plan for services not provided.

Example 4: South Florida General Practitioner

An out-of-network general practitioner in Delray Beach, Florida, billed a high number of procedures and charged higher prices for most of these procedures than other providers. Also, 10 of this provider's 11 patients reside outside Florida, raising questions about the claims paid to this and other providers in the area.

Table 5 compares this general practitioner's total claim activity with the average claim activity of all 32,672 general practitioners who submitted claims to the company from calendar years 2013 through 2015.

Table 5. Example of a South Florida General Practitioner's Claim Activity, 2013–2015

This Provider's Claim Activity		Average Claim Activity of all 32,672 General Practitioners
Payments	\$ 98,648	\$ 956
Number of Transactions	602	12
Number of Patients	11	2
Number of New Patients	11	0.36

Source: OIG analysis of Amtrak health care medical claims data

In addition, we identified the following multiple risk indicators in this general practitioner's billings that may indicate potential fraud:

High prices for each procedure. This provider's charges were more than double the average prices charged by all providers for 88 of the 95 procedures billed. For example, this provider charged the following:

- \$173 to \$2,125 for general health panel tests, compared to an average price of \$53 for all providers
- \$1,800 to \$11,500 for multiple tests for nine new patients on their first visits, compared to an average of \$82 for tests charged by all providers for their patients' first visits

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- an average of \$563 for new patient office visits, compared to an average of \$193 for all providers

This general practitioner also used a 60-minute new patient visit code, whereas other general practitioners more commonly used a lower cost 30-minute new patient visit code. This general practitioner used this code 11 times; other general practitioners who used this code used it only once, on average.

If the provider was paid the average amount for all of the higher-priced procedures, the company would have saved about \$70,000 from this provider's billing (about 71 percent).

High frequency of certain procedures. This general practitioner submitted a higher number of claims for certain procedures than other general practitioners. Most of this provider's claims, about \$80,000 (81 percent), were for pathology and laboratory tests in this provider's office. For example, this provider submitted claims for the following:

- 544 laboratory tests for 10 patients in 3 years, an average of 54 tests per patient—whereas the average number for all general practitioners was fewer than 5 tests per patient over the same period
- 26 to 48 different tests on 9 first visits, whereas the average for all general practitioners was about 3 tests on their patients' first visits (In addition, this provider submitted claims for 20 to 25 of those tests again on 3 patients' subsequent visits.)
- at least one test twice on the same day for six patients—once by this provider and again by an independent laboratory or substance abuse treatment facility

High number of shared patients. This general practitioner shared all 11 patients with 198 other facilities, which cost the company about \$5 million from calendar years 2013 through 2015. All of this provider's patients had a high number of claims from multiple substance abuse treatment centers, laboratories, and other individual medical service providers. Further,

- Eight other individual medical service providers who were among the 504 we identified with other suspicious billing patterns also submitted claims for services to 7 of this provider's patients—mostly additional laboratory testing. All of this provider's patients received additional testing—frequently daily or every two days—at a total cost of about \$2.5 million from other facilities, mainly laboratories and substance abuse treatment centers.

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- Two providers with shared patients submitted claims for the same tests for the same patient on at least 107 dates. For example, two laboratories submitted claims for 18 tests for the same patient on the same day. In another example, a pediatrician and a laboratory submitted claims for 10 tests for the same patient on the same day.

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APPENDIX C

Contract Clauses Relevant to Preventing and Detecting Fraud in Medical Claims

To help limit opportunities for fraud, contracts with the company's claim administrators have stipulated the following:

- **Aetna** shall contact Amtrak's OIG Office of Investigations to report any suspected fraudulent activities by providers or members, including but not limited to, significant overpayments, duplicated billings, trends, etc., at 1-800-468-5469 or <http://www.amtrakoig.gov>.
- **Total Health Plan** shall contact Amtrak's OIG Office of Investigations to report any suspected fraudulent activities by providers relating in any way to Amtrak or Amtrak participants, including but not limited to significant overpayments, duplicated billings, trends, etc., at 1-800-468-5469 or <http://www.amtrakoig.gov>.

In addition, Total Health Plan shall take steps to identify, recover and/or adjust claims under- and overpayments; provided that Contractor has no obligation to initiate litigation related to such services. Contractor's administrative costs for claims payment adjustment and recovery services are not included in the Monthly Administrative Fee. Effective for any recoveries received after the Effective Date, Amtrak shall pay for these services on a contingency basis as follows: (i) 25% of any recovery received if the recovery is made directly by Contractor; and (ii) if the recovery is made by Contractor's subcontractor, the amount of the contingency fee specified in Contractor's contract with that subcontractor. In either case, Contractor will credit the amounts received as a result of these adjustment and recovery services, net of the contingency fee, at least annually; if no recovery is received, Amtrak pays no fee for services rendered.

Resolution of overpayments, particularly those due to suspected or proven fraudulent claims, may involve the use of statistical sampling methodologies and extrapolating results over the universe of claims submitted by Providers or Intermediaries; in these cases, Amtrak's share of the recovery will be based upon these statistical methodologies and not on a claim-by-claim determination of payments.

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APPENDIX D

Abbreviations

FBI	Federal Bureau of Investigation
GAO	Government Accountability Office
HHS	U.S. Department of Health and Human Services
HHS OIG	Office of Inspector General of the U.S. Department of Health and Human Services
HR	Amtrak Human Resources department
OIG	Amtrak Office of Inspector General
the company	Amtrak
Tufts	Total Health Plan

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APPENDIX E
Management Comments

NATIONAL RAILROAD PASSENGER CORPORATION

Memo



Date	March 8, 2018	From	 Robin McDonough, VP Human Resources
To	Stephen Lord, Assistant Inspector General, Audits	Department	Administration/Human Resources
		cc	Eleanor Acheson Bill Feidt Stephen Gardner Tim Griffin Carol Hanna Byl Herrmann Kenneth Hylander Denyse Nelson-Burney Scot Naparstek DJ Stadler
Subject	Management Response to <i>Governance: Opportunities to Improve Controls over Medical Claim Payments</i> (Draft Audit Report for Project No. 015-2014)		

This memorandum provides Amtrak's response to the audit report for Project No. 015-2014 entitled, "*Governance: Opportunities to Improve Controls over Medical Claim Payments*". Management appreciates the opportunity to respond to the OIG recommendations. As indicated in our responses, we agree with each of the OIG recommendations and will initiate actions to address each in a timely manner.

Recommendation 1:

Develop and implement a cost-effective plan to address the vulnerabilities we identified by using a business case to guide its decision making and spending priorities. In doing so, the company should consider incorporating the leading practices we discussed such as:

- Requiring claim administrators to design and implement controls specifically tailored to detect and prevent potential fraud in the company's medical plan.
- Including appropriate performance guarantees in claim administrators' contracts to prevent and detect fraud, as well as criteria to measure their performance.
- Requiring regular assessments of the effectiveness of claim administrators' controls for preventing and detecting potential fraud, and implementing additional controls, as necessary, to address any identified gaps.
- Systematically analyzing and documenting assessments of the company's medical claims data to identify indicators of potential fraud, and use this information to implement additional fraud controls as needed.

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Management Response/Action Plan: Management agrees with the recommendation and will consider implementing the leading practices discussed where appropriate. The Vice President of Human Resources along with the Amtrak Benefits Director will develop and implement a plan to regularly assess and address vulnerabilities under the Amtrak Plan relative to fraud and abuse on a cost-effective, HIPAA compliant basis. Examples of potential components of the plan include:

- Regular assessment and analysis of operational data as well as claims data via independent third-party business associate partners (e.g., audit firms) relative to potential vulnerabilities to fraud and abuse, along with development of action plans to address identified gaps and/or opportunities for improvement (e.g., added controls) where appropriate.
- Based on this assessment and analysis and/or based on leading industry trends with respect to the claims administrators' contracts:
 - Consider the addition of and/or customization of controls relative to the Amtrak Plan
 - Consider the addition of and/or customization of performance guarantees relative to the Amtrak Plan

Responsible Amtrak Official(s): Vice President of Human Resources and Director of Benefits

Target Completion Date: Plan will be developed and implemented by 7/31/18; completion of plan will be approximately a full year from implementation.

Recommendation 2:

Consider reviewing the claims submitted by the medical service providers we identified for risk of potential fraud, and refer any providers whose activities should be further investigated to our office.

Management Response/Action Plan: Management agrees with the recommendation and will conduct a cost/benefit analysis and consider directing additional review of the claims submitted by the medical service providers identified by the OIG for risk of potential fraud. If it is deemed appropriate, the review would be conducted by the claims administrator or by an independent third-party review firm in a HIPAA compliant manner. If such an additional review is performed, any providers whose activities should be further investigated will be referred to the OIG.

Responsible Amtrak Official(s): Director of Benefits

Target Completion Date: 12/31/2018

Recommendation 3:

Seek recovery—to the extent cost-effective and practical—of the \$23.4 million in potential improper payments identified in this report.

Management Response/Action Plan: Management agrees with the recommendation and will seek recovery of the \$23.4 million in claims, or any portion thereof that are deemed to be improper payments based on the additional review performed under Recommendation 2 above.

Responsible Amtrak Official(s): Director of Benefits

Target Completion Date: 02/28/2019

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APPENDIX F

OIG Team Members

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Jay McKey, Contractor

OIG MISSION AND CONTACT INFORMATION

Mission

The Amtrak OIG's mission is to provide independent, objective oversight of Amtrak's programs and operations through audits and investigations focused on recommending improvements to Amtrak's economy, efficiency, and effectiveness; preventing and detecting fraud, waste, and abuse; and providing Congress, Amtrak management, and Amtrak's Board of Directors with timely information about problems and deficiencies relating to Amtrak's programs and operations.

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Available at our website www.amtrakoig.gov

Reporting Fraud, Waste, and Abuse

Report suspicious or illegal activities to the OIG Hotline

www.amtrakoig.gov/hotline

or

800-468-5469

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