



**OFFICE *of* INSPECTOR GENERAL**  
NATIONAL RAILROAD PASSENGER CORPORATION

## **GOVERNANCE:**

**Controls to Avoid Duplicate Medical Payments of Agreement Employees Appear Generally Effective, but Some Payment Errors Still Occur**

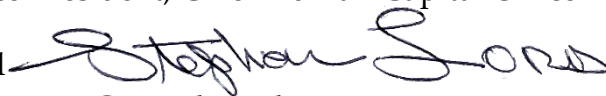
**OIG-A-2016-009 | July 15, 2016**

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## Memorandum

**To:** Alex B. Melnkovic  
Executive Vice President, Chief Human Capital Officer

**From:** Stephen Lord   
Assistant Inspector General, Audits

**Date:** July 15, 2016

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

Amtrak's (the company) group medical plan is self-insured and pays its healthcare costs directly from the company's operating budget. During calendar years (CY) 2011 through 2014, the company paid an estimated \$1.1 billion in claims filed by medical service providers such as doctors, hospitals, and medical laboratories. About \$911 million of these claims—83 percent of the total—were submitted on behalf of about 58,000 employees, retirees, and dependents covered under union agreements (agreement employees).

The company outsources the process for paying these claims to third-party claim administrators. These administrators provide employees with access to a network of medical service providers and process medical service claims submitted by these and other providers. Claim administrators sometimes make errors in paying medical claims, such as making overpayments for services provided or making payments for services not provided. Other errors include a vulnerability known as "duplicate" payments, which can occur when a medical service provider is paid two or more times for the same medical service.

This report focuses exclusively on duplicate payments. It was completed as part of an ongoing body of work examining the company's controls over payments for medical claims. For this review, our objective was to determine whether potentially duplicate payments were made to medical service providers for services rendered to agreement employees. Our review focused on potential duplicate payments for medical claims

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filed on behalf of agreement employees because of their aggregate value and associated risk to the company. Using a specialized data-analytics tool, we analyzed all of the 2.5 million medical claims paid in CY 2011 through CY 2014. We discuss our scope and methodology in more detail in Appendix A.

**BACKGROUND**

To administer its medical benefits plan, the Human Capital department contracts with third-party claim administrators. In CY 2011 and CY 2012, the company used United Healthcare as the third-party claim administrator for services rendered to agreement employees. It used Aetna for services rendered to agreement employees in CY 2013 and CY 2014. For agreement employees living in Massachusetts, Total Health Plan (also known as Tufts) administered the claims for services rendered to those employees in CY 2011 through 2014.

Claim administrators enroll employees in a medical plan and give them access to a network of medical service providers with whom the administrators have contracted negotiated rates for medical services. Employees can receive medical services from providers in the administrator's network, or they can go to out-of-network providers but pay more for each service. Providers collect a copay or coinsurance payment from employees, when applicable, and submit a claim for the remaining bill amount to the administrators. The administrators process and pay these claims based on the negotiated rates, then collect money from the company to pay for them.

These claims typically include such information as the medical provider's identification number, medical provider's name, patient's name, service location, diagnosis code, service date range, medical procedure code, and the billed amount. Doctors, hospitals, and laboratories compile and submit claims to the administrators using different methods, which can complicate the administrators' efforts to ensure accurate reimbursements for specific services provided to agreement employees.

**CONTROLS TO AVOID DUPLICATE MEDICAL PAYMENTS APPEAR GENERALLY EFFECTIVE, BUT PAYMENT ERRORS STILL OCCUR**

Our review of \$911.4 million in medical payments over the four year period of CY 2011 through 2014 identified \$4.3 million—about 0.5 percent—as potentially duplicate. This amount is significant given the company's ongoing efforts to reduce costs and achieve greater operational efficiencies. The company may be able to achieve cost-savings by

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researching these potentially duplicate payments and seeking the recovery of overpayments where appropriate.

To prevent and detect duplicate payments for medical services, the Human Capital department relies on automated and manual controls used by the third-party claim administrators.<sup>1</sup> The automated controls identify potential duplicate transactions by matching combinations of data categories such as provider number, patient number, service date, service location, and billed amount. The administrators then manually review and adjudicate these claims. These administrators also use other automated tools to proactively review claims after they are paid to detect overpayments or fraud.<sup>2</sup>

In addition, the administrators contract with outside firms to conduct annual audits to evaluate the adequacy and effectiveness of their claim-processing controls.<sup>3</sup> The three most recent audits<sup>4</sup> identified no material control weaknesses related to detecting duplicate claims. The administrators provide reports of these audits to their clients such as Amtrak to provide additional assurance about the adequacy and effectiveness of their claim-processing controls. A senior official from the Human Capital department stated that the company's Human Capital and Finance departments review these annual audit reports to help assess the adequacy of the claim-processing controls. Officials from the Human Capital department stated that the administrators' controls are highly effective and provide reasonable assurance that duplicate payments are being prevented or detected.

While we found that administrators' controls appear generally effective in detecting duplicate medical payments, we also found that payment errors can still occur and go undetected. Further, the Human Capital department has not independently validated whether administrators' controls are adequate in preventing improper disbursements—

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<sup>1</sup> An internal control system, including automated and manual controls, is a continuous built-in component of operations, affected by people, that provides reasonable assurance, not absolute assurance, that an entity's objectives will be achieved.

<sup>2</sup> These are the automated and manual control processes for Aetna and United Healthcare. We did not inquire about the control process used by Total Health Plan because we considered the amount of its total potential duplicate payments to be insignificant in comparison to the other third-party claim administrators.

<sup>3</sup> These annual audits are known as Service Organization Controls. The company provided annual audit reports from Aetna and United Healthcare but did not provide such reports from Total Health Plan.

<sup>4</sup> These audits covered the period from January 2012 through September 2014. They did not cover claims paid to United Healthcare in November and December 2012.

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such as duplicate payments—since 2011. Finally, best practices for the private and public sectors state that ongoing monitoring, separate evaluations, or a combination of the two, are useful in providing additional assurance of the operating effectiveness of key management control processes.

In the past, the Human Capital department contracted with an outside firm specializing in performing independent audits of healthcare claims to help validate the effectiveness of controls used by the third-party claim administrators. That audit performed in 2011<sup>5</sup> covered about \$352 million in medical claims paid from January 1, 2009 through November 30, 2010, and identified about \$446,000 in confirmed overpayments, including about \$49,000 in duplicate payments, from a sample of 400 transactions reviewed.

Because of the company's five-year gap in independently monitoring and evaluating the administrators' controls, we used our data-analytics tool to identify potential duplicate payments made from CY 2011 through CY 2014. We identified \$4.3 million in potentially duplicate payments made over this period. These payments represent about 0.5 percent of the total claims paid (about \$911 million).

We used a different approach than the claim administrators used to identify potential duplicate payments. Our approach identified a payment as a potential duplicate only if we matched claims across *six data categories*—provider name, patient name, service date, medical procedure code,<sup>6</sup> modifier code,<sup>7</sup> and paid amount. Using *fewer than six data categories* to match claims would have likely yielded more potential duplicates. Additionally, we considered two claims for the same drug dispensed on the same date—but with different claim numbers—to be potential duplicates that warranted additional review. The administrators might not consider these payments to be duplicates if both claims are filed within either the daily or the yearly limits on dispensing the drug.

Our results could suggest that the controls put in place by the third-party claim administrators may not be sufficient to prevent all duplicate payments. However, we

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<sup>5</sup> The company hired Healthcare Horizons Consulting Group, a firm specializing in performing independent audits of healthcare claims, to perform this audit. The audit report was issued on September 30, 2011.

<sup>6</sup> Procedure codes are numeric or alphanumeric designations identifying medical services and procedures used by medical service providers for billing.

<sup>7</sup> Modifier codes are used to further describe variations of the procedure codes and are used only as needed.

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recognize that additional analysis by company officials and the administrators is needed to determine if the payments we identified were in fact duplicates. Table 1 shows the amount of potentially duplicate medical payments made by each of the company's third-party claim administrators.

**Table 1. Potential Duplicate Payments by Claim Administrators**

Third-Party Claim Administrators	Period	Medical Claims Paid (in Millions)	Potential Duplicates (in Millions)
<b>Aetna</b>	CY 2013–CY 2014	\$435.1	\$2.4 <sup>a</sup>
<b>United Healthcare</b>	CY 2011–CY 2014 <sup>b</sup>	\$453.0	\$1.9
<b>Total Health Plan</b>	CY 2011–CY 2014	\$23.3	\$0.0 <sup>c</sup>
<b>Totals</b>		<b>\$911.4</b>	<b>\$4.3</b>

*Source:* OIG analysis of Amtrak healthcare medical claims data

**Notes:**

<sup>a</sup> Includes 10 potentially duplicate claims of \$223,805 already shared with Aetna for additional review.

<sup>b</sup> Includes claim payments issued by United Healthcare in 2013 and 2014 during the transition to Aetna who now serves as the company's third-party claim administrator.

<sup>c</sup> We identified less than \$7,000 in potential duplicate claims paid by Total Health Plan.

During our audit, we provided one of the third-party claim administrators with a sample of 10 potential duplicates valued at \$223,805 that we selected to help validate our approach. The administrator confirmed that two of these payments were duplicates totaling about \$8,000, and one was a payment that was adjudicated incorrectly resulting in an overpayment of \$41,000. The administrator further stated that it had started working to recover the funds. These results may indicate there is a broader issue with overpayments that are going undetected, but we did not focus on identifying overpayments in this review.

Because we selected this sample of 10 potential duplicates through non-random means, it is important to note that these figures cannot be used to develop a broader estimate of duplicate payments, or overpayments. However, because the third-party claim administrator confirmed that some of the payments were errors, the company could benefit by having the administrators review the remaining potentially duplicate payments we identified.

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As part of our methodology, we shared our test results with Human Capital department officials. Those officials agreed that further review of these potentially duplicate payments might result in additional cost-savings if the cost of reviewing and pursuing the recovery of these payments is less than the amount recovered. In addition, during our audit, a senior official from the Human Capital department told us that the department was considering contracting for another independent audit to help identify duplicate payments but did not provide a timeframe. If implemented, this additional step would help management strengthen its internal controls and improve the company's level of assurance in detecting and recovering duplicate payments, and preventing potential fraud.

**CONCLUSIONS**

The company has established a management control process to help identify potentially duplicate claims submitted by medical service providers for about 58,000 agreement employees, retirees, and dependents that appears generally effective. However, we identified additional opportunities for recovering \$4.3 million in potentially duplicate payments using a different testing methodology than the one used by the third-party claim administrators charged with detecting questionable payments. Also, the Human Capital department could take additional actions to enhance its monitoring of this process rather than relying exclusively on third-party claim administrators' controls for assurances about the adequacy of these controls by reinstating the use of an independent assessment. Any additional cost savings gleaned from these efforts will contribute to current company-wide efforts to achieve greater operating efficiencies and cost reductions.

**RECOMMENDATIONS**

We recommend that the Executive Vice President/Chief Human Capital Officer consider taking the following actions:

1. Direct third-party claim administrators to review potentially duplicate payments that we identified, if cost-effective, to recover additional company funds, as appropriate.
2. Apply a testing methodology, such as the one we have developed, for proactively reviewing the paid medical claims for potential duplicates.



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3. Develop a cost-effective plan and timeframes for monitoring future medical claims using an independent assessment.

**MANAGEMENT COMMENTS AND OIG ANALYSIS**

In commenting on a draft of the report, the company's Executive Vice President/Chief Human Capital Officer agreed with two recommendations and partially agreed with one. He also cited proposed actions that, if fully implemented, might help meet the intent of the recommendations. The company's planned actions are summarized below, and Appendix B contains management's complete response.

**Recommendation 1:** Management agrees with the recommendation and will request the third-party claim administrators to review the broader set of potential duplicate payments we identified.

**Recommendation 2:** Management agrees with the general intent of our recommendation but did not agree with our recommended approach for proactively reviewing the paid medical claims for potential duplicates. Management stated that it does not believe the proactive review of duplicate payments would be an efficient use of limited resources given the existence of other controls and current accuracy rates, and cited other steps they take to help identify duplicate payments on a retroactive basis. This includes relying on performance guarantee reports produced by the third-party claim administrators, the annual audits known as Service Organization Control audits (referred to as SSAE 16 reports in management's response) performed on third-party claim administrators' controls, and the audits performed by firms specializing in reviewing medical claims to identify potential duplicate payments.

These company actions might help identify some duplicate payments but our approach has merit as it could proactively identify potentially duplicative payments before any of the steps cited above by management were completed.

**Recommendation 3:** Management agrees with the recommendation and will schedule audits performed by independent audit firms that specialize in reviewing medical claims every two to three years.

The company's Human Capital Benefits management also provided technical comments on the draft report that we incorporated into the final report where appropriate.

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**APPENDIX A****Scope and Methodology**

This report provides information on potential duplicate payments of medical claims processed from CY 2011 through CY 2014. The scope of our work included interviewing officials from the Human Capital department and working with the third-party claim administrator representatives to obtain and understand the data in their systems. We performed our work from December 2014 through May 2016 in Washington D.C.

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

- United Healthcare<sup>8</sup> for CY 2011 and CY 2012
- Aetna for CY 2013 and CY 2014
- Total Health Plan (also known as Tufts) for medical claims paid for employees in Massachusetts from CY 2011 through CY 2014

Claim administrator officials advised us that the data did not include all manual check payments to providers, pending receivables from providers, and recoveries from providers. We deemed the missing data to be insignificant because the paid claims data received from the administrators was more than 99 percent complete when validated against company's financial system.

Using the data-analytics tool, we determined whether two or more claims were potentially paid for the same services performed by the same provider for the same patient. We did so by matching each line item in a claim with a line item in a different claim in all of the following six categories—provider name, patient name, service date, medical procedure code,<sup>9</sup> modifier code, and paid amount. Our approach to identify potential duplicates was conservative because we matched claims on all six of these

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<sup>8</sup> The United Healthcare contract expired on December 31, 2012, and Aetna became the new third-party claim administrator for agreement employees as of January 1, 2013. Our analyzed data also included about \$20 million in claims that were processed and paid by United Healthcare in CY 2013 and CY 2014 for the services rendered prior to January 1, 2013.

<sup>9</sup> This code is frequently omitted in claims submitted by hospitals and other medical facilities.

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data categories. Matching claims on less than six data categories would have likely produced more potential duplicates.

Claim administrator officials advised us that even if information in these six categories matched and both claim line items were paid on the same date and on the same claim number, they might not be duplicates. For example, a provider may bill five units of service in the same claim using five different claim line items, but these should not be considered duplicates. Thus, we removed any items meeting this criterion from our analysis. In identifying the potential duplicate amounts, we also removed the claims that were reversed (credited).

To assess the company's control and monitoring processes for preventing or detecting duplicate medical claim payments, we reviewed and analyzed internal controls used by the company against those in the private and public sectors. This included identifying and applying standards for control activities, monitoring, and performance of processes described in the Committee of Sponsoring Organizations of the Treadway Commission's *Internal Control—Integrated Framework* and the U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government*.

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.

## **Internal Controls**

We focused our control work on identifying the procedures the company used to prevent and detect duplicate 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. We did not review the entire system of controls that ensures claims submitted by the medical providers were appropriate and in compliance with the company's medical plan.

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**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 in the following manner:

- For medical claims paid in CY 2011 through CY 2013, we compared the administrators' payment records with the company's financial records and found a 99.98 percent agreement rate. We also compared the total claim payment amounts in the administrators' data (excluding data from Total Health Plan)<sup>10</sup> to the claim payment amount provided by Verisk, the contractor who collects and consolidates healthcare data from all administrators and generates reports for the Human Capital department. We found a 99.95 percent agreement rate.
- For medical claims paid in CY 2014, we matched the total claim payment amounts in the administrators' data with totals provided by Verisk. We found a 99.31 percent agreement rate.

Based on these tests, we believe that the data were sufficiently reliable for meeting our objectives.

**Prior Audit Reports**

We reviewed the following audit reports from the Healthcare Horizons Consulting Group relevant to our work:

- *National Railroad Passenger Corporation (AMTRAK), AETNA Claims Audit Report, January 27, 2012*
- *National Railroad Passenger Corporation (AMTRAK), United Healthcare Claims Audit Report, September 30, 2011*
- *National Railroad Passenger Corporation (AMTRAK), United Healthcare Claims Audit Report, July 31, 2009*

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<sup>10</sup> Verisk did not have a full data set from Total Health Plan for 2011; therefore, we excluded all of its CY 2011–CY 2013 data for validation.

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**APPENDIX B****Comments from the Chief Human Capital Officer**

NATIONAL RAILROAD PASSENGER CORPORATION

Memo



Date June 24, 2016

 From A. Barry Melnkovic   
 Executive Vice President and Chief  
 Human Capital Officer

 To Stephen Lord  
 Assistant Inspector General, Audits

Department Human Capital

 Subject Governance: Controls to Avoid  
 Duplicate Medical Payments of  
 Agreement Employees Appear  
 Generally Effective, but Some  
 Payment Errors Still Occur (Audit  
 Report No. 014-2016)

 cc David Roberts, Senior Vice President,  
 Total Rewards Health & Wellness  
 Gerald Sokol, Executive Vice  
 President, Chief Financial Officer  
 DJ Stadtler, Executive Vice President  
 and Chief Operations Officer  
 William Herrmann, Vice President,  
 Deputy Managing General Counsel  
 Matthew Gagnon, Senior Director,  
 Amtrak Controls

This memo serves as management's response to the audit report from the Office of Inspector General, *Governance: Controls to Avoid Duplicate Medical Payments of Agreement Employees Appear Generally Effective, but Some Payment Errors Still Occur* (Audit Report No. 014-2016). Management has reviewed the OIG's report in its entirety and is in agreement with the finding that current controls are generally effective. Additionally, management is committed to developing and implementing any necessary internal controls as deemed reasonable and appropriate to address the associated risks that exist around payment errors.

Recommendation 1:

Direct third-party administrators to review potentially duplicate payments that we identified, if cost-effective, to recover additional company funds that could be put to better use.

Management Response/Action Plan:

Human Capital Benefits management compares Amtrak's results against the thresholds applied in the case of claims administration financial accuracy benchmarks and based on review of the OIG analysis

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concluded that the rate of accuracy would fall between 99.54% and 99.98%, well within industry norms for financial accuracy.

Human Capital Management will continue to review and implement appropriate controls to mitigate risks to a reasonable level. With this in mind, Director of Benefits will request the third-party administrators to review the broader set of potential duplicate claim payments as identified by OIG. This may be subject to contractual provisions and additional associated costs that may be incurred for conducting these reviews. If appropriate, the third-party claim administrators will be requested to seek recoveries of duplicate payments from providers by December 2016. Management has opted not to seek recoveries from plan participants in accordance with industry norms.

Recommendation 2:

Apply a testing methodology, such as the one we have developed, for proactively reviewing the paid medical claims for potential duplicates.

Management Response/Action Plan:

Human Capital Benefits management agrees with the general intent of the recommendation to review paid medical claims for potential duplicates. Human Capital Benefits management already has controls in place and does not believe applying a new testing methodology would be an efficient use of limited resources given the rate of accuracy exceeding 99.54%.

Human Capital Benefits management will continue to review the annual results of the third-party claim administrator's performance guarantees with the Joint Medical Administration Committee (JMAC), the named fiduciaries of AmPlan. The AmPlan medical performance guarantees with Aetna include a Financial Accuracy rate of 99.2% or better.

On an annual basis, management will continue to review each Statement on Standards for Attestation Engagements (SSAE) 16 report on Amtrak's third party claims administrators to address any control exceptions noted that have an effect on Amtrak's control environment as well as document Amtrak's adherence to applicable user control considerations identified within the report.

Human Capital Benefits management will also leverage external audit firms that have dedicated systems and processes inclusive of sophisticated testing methodologies. The audit firms will verify the adherence to the performance guarantees, identify overpayments and potential duplicates as noted in the response to Recommendation 3.

Recommendation 3:

Develop a cost-effective plan and timeframes for monitoring future medical claims using an independent assessment.

Management Response/Action Plan:

Human Capital Benefits management agrees with the recommendation and will adhere to a regular schedule of audits (e.g. every 2-3 years) performed by independent specialized claim auditing firms in

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adherence with industry best practices, inclusive of testing methodology approaches. These audits will include the review for potential duplicate claim payments.

All audits will be performed on a timely but retroactive basis, after claims are paid. Proactive review of claims (prior to payment of claims) will be based on the claim administrators' controls – however, these retroactive audit reviews will provide timely review and identify any needed improvements in the claim administrators' controls. The first such audit will be underway by the end of 2016. The Director of Benefits will oversee the audit.

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**APPENDIX C**

**Acronyms and Abbreviations**

CY	calendar year
OIG	Amtrak Office of Inspector General
the company	Amtrak



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**APPENDIX D**

**OIG Team Members**

Vijay Chheda	Senior Director, Audits
Alejandra Rodriguez	Senior Audit Manager
Ben Davani	Senior Operations Analyst
Jay McKey	Contractor
Juan Morales	Contractor

# OIG MISSION AND CONTACT INFORMATION

## Mission

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## Contact Information

**Stephen Lord**

**Assistant Inspector General, Audits**

Mail: Amtrak OIG

10 G Street, NE, 3W-300

Washington D.C. 20002

Phone: 202-906-4600

Email: [Stephen.Lord@amtrakoig.gov](mailto:Stephen.Lord@amtrakoig.gov)