Department of Health and Human Services
Office of Inspector General
Office of Audit Services

July 2025 | A-04-24-07110

Pennsylvania Made More Than $8.7 Million in Unallowable Capitation Payments for Enrollees With Multiple Medicaid Identification Numbers

REPORT HIGHLIGHTS

July 2025 | A-04-24-07110

Pennsylvania Made More Than $8.7 Million in Unallowable Capitation Payments for Enrollees With Multiple Medicaid Identification Numbers

Why OIG Did This Audit

Previous Office of Inspector General (OIG) audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements. Specifically, some enrollees in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid capitation payments for these enrollees.

What OIG Found

Pennsylvania made unallowable capitation payments on behalf of enrollees with multiple Medicaid ID numbers.

- Of the 100 enrollee-matches in our sample, the State agency correctly made capitation payments on behalf of individuals associated with 2 enrollee-matches; however, the State agency incorrectly made capitation payments—totaling $1,068,308 ($559,087 Federal share)—on behalf of individuals associated with the remaining 98 enrollee-matches.
- The unallowable capitation payments occurred because the State agency's controls were insufficient to detect or prevent multiple Medicaid ID numbers from being assigned to the same enrollee.
- On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least $8,784,549 ($4,596,390 Federal share) on behalf of enrollees with multiple Medicaid ID numbers during our audit period.

What OIG Recommends

We made five recommendations to Pennsylvania, including that it refund an estimated $4.6 million to the Federal Government. The full recommendations are in the report.

Pennsylvania concurred with two of our recommendations and did not indicate concurrence or nonconcurrence with three additional recommendations. However, it detailed steps it has taken or plans to take in response to those recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Previous Office of Inspector General (OIG) audits identified Federal Medicaid reimbursement for managed care payments that were not claimed in compliance with Federal requirements.[1] Specifically, some enrollees in Medicaid managed care had more than one Medicaid identification (ID) number. As a result, Medicaid managed care organizations (MCOs) received unallowable monthly Medicaid capitation payments for these enrollees.

OBJECTIVE

Our objective was to determine whether the Pennsylvania Department of Human Services (State agency) made unallowable capitation payments on behalf of enrollees with multiple Medicaid ID numbers.

BACKGROUND

The Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (Title XIX of the Social Security Act (the Act)). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. The State plan establishes which services the Medicaid program will cover. Although a State has considerable flexibility in designing and operating its Medicaid program, it must comply with Federal requirements.

Pennsylvania's Medicaid Managed Care Program

The Office of Medical Assistance Programs (OMAP) administers Pennsylvania's Medicaid program. OMAP oversees quality management and innovation in Medicaid and is also responsible for contracting and monitoring MCOs. Through MCOs, eligible individuals receive quality physical and behavioral medical care, as well as long-term support.

Capitation Payments

The State agency pays MCOs a monthly fee, known as a capitation payment, to ensure that an enrollee has access to a broad range of covered medical services. A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled

[1] See Appendix B for related OIG reports.

under a contract . . . for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2). The MCO is required to make full and prompt restitution to the State agency, as directed by the State agency, for overpayments received, whether such overpayment is discovered by the MCO, the State agency, or a third party.[2]

File Clearance Process and Establishing a Medicaid ID Number

The State agency's policies and procedures state that when an application for Medicaid benefits is received, the State agency searches the Master Client Index (MCI) database to determine whether the individual has applied for, previously received, or is currently receiving Medicaid benefits. This process is intended, in part, to prevent the State agency from assigning duplicate ID numbers to a Medicaid recipient.

Two queries are performed during what is called a file clearance. First, the State agency performs a Social Security Number (SSN) match search to determine whether an individual has an existing Medicaid ID number in the system that correlates to an SSN. If the individual does not have an ID number, the State agency performs a name search to determine whether an individual with the same name has an existing Medicaid ID number. If there is no name match, then the individual is deemed a new applicant, and a new Medicaid ID number will be assigned. However, if there is a name match, the State agency uses an algorithm that assigns points based on demographic information provided within the application to determine whether a new Medicaid ID number should be created. The following describes the various steps used in that algorithm:

(1) If there is an exact match of first name, last name, and date of birth (DOB), then the algorithm scores the applicant as a 100 percent match, and it will assign the individual's existing Medicaid ID number.

(2) If only the SSN matches, the algorithm scores the applicant as a 99 percent match, and it will assign the matching Medicaid ID number.

(3) If neither of the exact matches listed above exists, the algorithm assigns points to any partial demographic information that may match, such as similar SSN digits. Scores between 70 and 98 percent will net a list of potential matches. A case worker will then conduct additional research to determine whether any of the potential matches are the same individual.

(4) If the algorithm determines a score of less than 70 percent, the system will assign a new Medicaid ID number to the applicant.

[2] This language was included in the applicable MCO agreements during our audit period.

HOW WE CONDUCTED THIS AUDIT

We limited our audit to Medicaid capitation payments that the State agency made to MCOs on behalf of Medicaid enrollees in Pennsylvania from January 1, 2019, through December 31, 2022 (audit period).[3] From a detailed list of capitation payments made to MCOs during our audit period, we identified 3,584 instances of individuals that we could match to more than one Medicaid ID number.[4] From these enrollee-matches,[5] for which the State agency made capitation payments totaling $19,846,784 ($10,390,232 Federal share), we selected and reviewed a stratified random sample of 100 enrollee-matches.

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 objectives.

Appendix A contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the Federal and State requirements.

FINDINGS

The State agency made unallowable capitation payments on behalf of enrollees with multiple Medicaid ID numbers. Of the 100 enrollee-matches in our sample, the State agency correctly made capitation payments on behalf of individuals associated with 2 enrollee-matches; however, the State agency incorrectly made capitation payments—totaling $1,068,308 ($559,087 Federal share)—on behalf of individuals associated with the remaining 98 enrollee-matches.

The unallowable capitation payments occurred because the State agency's controls were insufficient to detect or prevent multiple Medicaid ID numbers from being assigned to the same enrollee. On the basis of our sample results, we estimated that the State agency made

[3] The audit period encompassed the most current data available at the time we initiated our audit.

[4] Throughout this report, we will refer to multiple Medicaid ID numbers assigned to what appears to be an individual as "enrollee-matches." We define an enrollee-match as more than one Medicaid ID number associated with an individual that has (1) the same or similar first and last names, or the inverse of the same or similar first and last names, and (2) the same DOB.

[5] We performed data analytics to identify these 3,584 enrollee-matches.

unallowable capitation payments totaling at least $8,784,549 ($4,596,390 Federal share) on behalf of enrollees with multiple Medicaid ID numbers during our audit period.[6]

MANY ENROLLEES HAD MULTIPLE MEDICAID IDENTIFICATION NUMBERS

States generally must refund the Federal share of Medicaid overpayments to CMS (42 CFR § 433.312(a)). CMS defines overpayments as "the amount paid by a Medicaid agency to a provider which is in excess of the amount that is allowable for services furnished under section 1902 of the Act and which is required to be refunded under section 1903 of the Act" (42 CFR § 433.304). These include unallowable capitation payments made on behalf of the same enrollee for the same coverage of services.

The State agency claimed unallowable capitation payments on behalf of individuals associated with 98 sampled enrollee-matches because it assigned multiple Medicaid ID numbers to many enrollees. This resulted in an overpayment to the agency. Per the State agency contracts with the MCOs, the MCO shall make full and prompt restitution to the State agency, as directed by the State agency, for overpayments received in excess of amounts due to the MCO whether such overpayment is discovered by the MCO, the State agency, or other third party.

The State agency had some controls in place to prevent payments on behalf of enrollees assigned multiple Medicaid ID numbers. For example, the State agency went through the process of determining whether an individual already had an existing Medicaid ID number based on a match-scoring algorithm. If there was a 99 percent to 100 percent match based on name, SSN, and DOB, then the system would assign the individual that Medicaid ID number, with which it matched, and not create a new Medicaid ID number. If there was a 70 percent to 98 percent match based on various demographic information, then the system would offer potential matches and an option to create a new Medicaid ID number for that individual. If there was less than a 70 percent match based on various demographic information, then the system would assign a new Medicaid ID number.

The State agency also used its Zero SSN report, which contains individuals that already have a Medicaid ID number assigned but no SSN. According to the State agency's policies and procedures, staff members are responsible for checking the Zero SSN report monthly to determine whether individuals on the list, who originally did not have an SSN when issued a Medicaid ID, had subsequently been provided an SSN. If an SSN had been issued subsequently, then the staff member adds the SSN to that person's existing record. If the SSN is already linked to another Medicaid ID, but for the same person, the staff member will receive an error notification and will submit a request for the Medicaid IDs to be merged.

However, the State agency's controls were not sufficient to prevent or detect multiple Medicaid

[6] To be conservative, we recommend recovery at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

ID numbers from being assigned to the same enrollee. For example, the match-scoring algorithm that the State agency used to determine whether an individual had a Medicaid ID number was not effective because it did not always identify enrollees with the same first and last names and DOB as potentially being the same person; therefore, the State agency assigned them more than one Medicaid ID number. In addition, staff members did not consistently review the list of individuals in the Zero SSN report to determine whether they had been provided an SSN according to their policies and procedures. A State agency official said that the Zero SSN report was not updated during the COVID-19 public health emergency (PHE)[7] as officials prioritized other tasks, and the report continued to grow.

The unallowable capitation payments occurred because the State agency's controls, including its algorithm used during the file clearance process, were not sufficient to detect or prevent multiple Medicaid ID numbers from being assigned to the same enrollee. The State agency said other factors contributing to the unallowable payments were data entry errors and the fact that some individuals, such as newborns, did not have an SSN that could be used to compare information within the State's MCI.

ESTIMATE OF UNALLOWABLE CAPITATION PAYMENTS

On the basis of our sample results, we estimated that the State agency made unallowable capitation payments totaling at least $8,784,549 ($4,596,390 Federal share) on behalf of enrollees with multiple Medicaid ID numbers during our audit period.

RECOMMENDATIONS

We recommend that the Pennsylvania Department of Human Services take the following steps:

- refund to the Federal Government $4,596,390 in unallowable payments;
- review capitation payments subsequent to our audit period and refund any unallowable payments;
- use the Zero SSN report consistently and update it monthly, in accordance with the State agency's policy and procedures, to prevent the issuance of multiple Medicaid ID numbers for the same enrollee;
- test the match-scoring algorithm to ensure it is working as intended; and

[7] The COVID-19 PHE was issued by the Secretary of the U.S. Department of Health and Human Services on January 31, 2020, and ended on May 11, 2023. Since the onset of the PHE, with limited exceptions, State Medicaid agencies generally have not terminated the enrollment of any Medicaid enrollee who was enrolled on or after March 18, 2020, through March 31, 2023 (referred to as the continuous enrollment condition). The Medicaid continuous enrollment condition was authorized by the Families First Coronavirus Response Act (P.L. No. 116-127) (Mar. 18, 2020).

- enhance or establish new controls to prevent, detect, and correct instances where multiple Medicaid ID numbers are assigned to the same enrollee.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency concurred with our first and third recommendations and did not indicate concurrence or nonconcurrence with our second, fourth and fifth recommendations. However, it described the corrective actions that it has taken or plans to take to address them.

For the second recommendation, the State agency affirmed that capitation payments are monitored monthly for accuracy and allowable recovery. It also stated that it processes refunds for the Federal share on errors found.

For the fourth recommendation, the State agency stated that it is developing test-case scenarios for the match-scoring algorithm in the MCI and that it plans to test them with its June 2025 systems release.

For the fifth recommendation, the State agency is considering enhancements that would address our recommendation. In addition, the agency said staff training will continue to emphasize the importance of the file clearance process.

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

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $19,846,784 ($10,390,232 Federal share) in Medicaid capitation payments that the State agency made to MCOs from January 1, 2019, through December 31, 2022 (audit period) for 3,584 enrollee-matches, as defined in footnote 4.[8]

We did not review the overall internal control structure of the State agency's Medicaid program. Rather, we reviewed only those controls related to our objective. We limited our audit to determining whether MCOs in Pennsylvania received capitation payments on behalf of individuals who were assigned multiple Medicaid ID numbers, thus causing unallowable capitation payments.

We conducted this audit from January 2024 through April 2025.

METHODOLOGY

To accomplish our objective, we took the following steps:

- reviewed applicable Federal laws and regulations and State guidance;
- reviewed the State agency's policies and procedures on how it assigns Medicaid ID numbers and prevents the assignment of multiple Medicaid ID numbers to the same individual;
- performed data analytics to identify a sampling frame of 3,584 enrollee-matches;
- requested that the State agency provide a detailed list of capitation payments to MCOs from January 1, 2019, through December 31, 2022, for these enrollee-matches;
- selected a stratified random sample of 100 enrollee-matches from the sampling frame;
- reviewed computer records for each sample item to determine whether an enrollee was issued multiple Medicaid ID numbers; and
- estimated the total amount and the Federal share of unallowable Medicaid capitation payments in the sampling frame that the State agency made during our audit period.

[8] We performed data analytics to identify these 3,584 enrollee-matches.

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 objectives.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Office of Medicaid (MassHealth) - Review of Capitation Payments With Multiple Identification Numbers	A-01-23-00004	02/25/2025
Puerto Rico Claimed More Than $500 Thousand in Unallowable Medicaid Managed Care Payments for Enrollees Assigned More Than One Identification Number	A-02-21-01004	09/08/2023
California Made Almost $16 Million In Unallowable Capitation Payments for Beneficiaries With Multiple Client Index Numbers	A-04-21-07097	10/25/2022
Kentucky Made Almost $2 Million in Unallowable Capitation Payments for Beneficiaries With Multiple Medicaid ID Numbers	A-04-20-07094	12/02/2021
New York Made Unallowable Payments Totaling More Than $9 Million to the Same Managed Care Organization for Beneficiaries Assigned More Than One Medicaid Identification Number	A-02-20-01007	05/11/2021
Florida Made Almost $4 Million in Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid ID Numbers	A-04-18-07080	03/23/2020
New York Made Unallowable Payments Totaling More Than $10 Million for Managed Care Beneficiaries Assigned Multiple Medicaid Identification Numbers	A-02-18-01020	02/20/2020
Tennessee Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers	A-04-18-07079	10/29/2019
Georgia Made Unallowable Capitation Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers	A-04-16-07061	12/27/2017
Texas Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned More Than One Medicaid Identification Number	A-06-15-00024	3/01/2017
New York State Made Unallowable Medicaid Managed Care Payments for Beneficiaries Assigned Multiple Medicaid Identification Numbers	A-02-11-01006	4/15/2013

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame contained 3,584 enrollee-matches, which consisted of 32,867 individual capitation payments made to MCOs during our audit period totaling $19,846,784, and that had total net capitation payments greater than $100.

SAMPLE UNIT

The sample unit was an enrollee-match.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We divided the sampling frame into three strata as shown in Table 1:

Table 1: Details of Sampling Frame

Stratum	Description of Stratum	Number of Sample Units in the Frame	Net Payment Amounts in the Frame	Sample Size
1	Net capitation total >$166.15 and <$7,179.16	2,946	$3,941,583	34
2	Net capitation total ≥$7,179.16 and <$31,344.65	472	8,192,094	33
3	Net capitation total ≥$31,344.65	166	7,713,107	33
Total		**3,584**	**$19,846,784**	**100**

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the enrollee-matches in each stratum by ascending total net capitation payment and then by ascending Medicaid ID number. Then we consecutively numbered the items in each stratum. After generating the random numbers for each stratum, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount and the Federal share of unallowable Medicaid capitation payments in the sampling frame. To be conservative, we recommend recovery of unallowable payments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual unallowable amount 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Enrollee-Matches in the Sampling Frame	Frame Value (Total)	Sample Size	Sample Value (Total)	Number of Enrollee-Matches with Overpayments in the Sample	Value of the Overpayments in the Sample (Total)	Value of the Overpayments in the Sample (Federal Share)
1	2,946	$3,941,583	34	$41,089	34	$26,952	$14,102
2	472	8,192,094	33	532,572	32	254,887	133,331
3	166	7,713,107	33	1,527,207	32	786,469	411,654
Total	**3,584**	**$19,846,784**	**100**	**$2,100,868**	**98**	**$1,068,308**	**$559,087**

Table 3: Estimated Value of Overpayments in the Sampling Frame (Limits Calculated at the 90-Percent Confidence Level)

	Total Amount	Federal Share
Point estimate	$9,937,110	$5,199,674
Lower limit	8,784,549	4,596,390
Upper limit	11,089,672	5,802,958

APPENDIX E: FEDERAL AND STATE REQUIREMENTS

FEDERAL REQUIREMENTS

Section 1903(d)(2)(A) of the Social Security Act requires Federal Medicaid payments to a State to be reduced to make adjustment for prior overpayments. In addition, States are responsible for refunding the Federal share of overpayments to CMS (42 CFR § 433.312(a)).

The Federal Government pays its share of a State's medical assistance expenditures under Medicaid based on the Federal Medical Assistance Percentage, which varies depending on the State's relative per capita income as calculated by a defined formula (42 CFR § 433.10(a), (b)).

The Medicaid managed care program defines providers as "any individual or entity that is engaged in the delivery of health care services and is legally authorized to do so by the State in which it delivers the services" (42 CFR § 400.203).

A capitation payment is "a payment the State makes periodically to a contractor on behalf of each beneficiary enrolled under a contract . . . for the provision of services under the State plan. The State makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment" (42 CFR § 438.2).

STATE REQUIREMENTS

The applicable State contracts with the MCOs require the MCOs make full and prompt restitution to the State agency, as directed by the State agency, for overpayments received in excess of amounts due to the MCOs whether such overpayment is discovered by the MCOs, the State agency, or other third party (Pennsylvania MCO Agreements).

OIG NOTE: We revised the title of this final audit report to include the combined Federal and State share of the unallowable capitation payments. The draft report title only included the Federal share of the unallowable capitation payments. No revisions were made to the findings or recommendations.

APPENDIX F: STATE AGENCY COMMENTS

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

May 28, 2025

Mr. Truman Mayfield
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, Georgia 30303

Dear Mr. Mayfield:

This is in response to your letter dated April 22, 2025, which transmitted the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report number A-04-24-07110 titled *Pennsylvania Made Almost $5 Million in Unallowable Capitation Payments for Enrollees With Multiple Medicaid Identification Numbers*. The objective of this audit was to determine whether the Pennsylvania Department of Human Services made unallowable capitation payments on behalf of enrollees with multiple Medicaid ID numbers.

The draft report contains five recommendations. Below is each recommendation, followed by the Pennsylvania Department of Human Services' (DHS') response.

OIG Recommendation 1: We recommend that the Pennsylvania Department of Human Services refund to the Federal Government $4,596,390 in unallowable payments.

DHS Response: We concur with this recommendation. While acknowledging the erroneous payments, we also recognize that creation of multiple identification numbers occurs in the Eligibility and Enrollment (E&E) system, the source for all eligibility and enrollment data, rather than within the Medicaid Management Information System (MMIS), which issues capitation payments based on the incoming data provided. This distinction is critical to understanding and collaboratively remediating the complex issue. The successful resolution of multiple identification numbers includes timely notification to the MMIS staff by E&E staff, Managed Care Organization partners, and the Enrollment Assistance Broker. Once this notification occurs, steps are taken to close or merge the identification numbers in question and recover any incorrect capitation payments that were made.

OIG Recommendation 2: We recommend that the Pennsylvania Department of Human Services review capitation payments subsequent to our audit period and refund any unallowable payments.

DHS Response: We affirm that capitation payments are monitored monthly for accuracy and allowable recovery. Federal Share refund actions are taken on any errors found. This routine post-payment activity is ongoing regardless of the source of discovery. The unallowable payments identified in this audit have had applicable recoveries completed.

OIG Recommendation 3: We recommend that the Pennsylvania Department of Human Services use the Zero SSN report consistently and update it monthly, in accordance with the State agency's policy and procedures, to prevent the issuance of multiple Medicaid ID numbers for the same enrollee.

DHS Response: We concur with this recommendation. DHS' instructions for the use of the Zero SSN report, which is provided monthly, are articulated in Supplemental Handbook chapter 870 and Operations Memorandum 24-07-05. When appropriate action is taken based on those instructions, duplicate Medicaid ID numbers will be reconciled either through SSN matching or case closure. Once reconciliation action is taken by the caseworker, the enrollee will not appear on future reports.

OIG Recommendation 4: We recommend that the Pennsylvania Department of Human Services test the match-scoring algorithm to ensure it is working as intended.

DHS Response: We are currently developing test case scenarios for the match-scoring algorithm in the Master Client Index. We will run these regression tests with our upcoming June 2025 systems release, adding them to our ongoing regression tests.

OIG Recommendation 5: We recommend that the Pennsylvania Department of Human Services enhance or establish new controls to prevent, detect, and correct instances where multiple Medicaid ID numbers are assigned to the same enrollee.

DHS Response: We are currently looking into enhancements that would address this recommendation. Training by staff development will continue to emphasize the importance of the file clearance process, which is an integral part of the clerical staff training. If any system enhancements are identified, they will be documented and submitted through our prioritization process.

Thank you for the opportunity to respond to this report. If you have any questions, please contact Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section, at (717) 783-7217 or davbryan@pa.gov.

Sincerely,

Stephanie Shell
Deputy Secretary for Administration

c: Ms. Denise Novak, Office of Inspector General
Mr. David Bryan, Bureau of Financial Operations, Audit Resolution Section

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