DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

DEC 31 2003

TO: William H. Gimson
Chief Operating Officer
Centers for Disease Control and Prevention

FROM: Dennis J. Duquette
Deputy Inspector General
for Audit Services

SUBJECT: Identification and Allocation of Indirect Costs at the Centers for Disease Control and Prevention (A-04-02-08001)

Attached are two copies of the Office of Inspector General report entitled *Identification and Allocation of Indirect Costs at the Centers for Disease Control and Prevention.* The objective of our self-initiated audit was to determine whether the Centers for Disease Control and Prevention (CDC) had established a system to properly identify the costs of organization-wide indirect activities and equitably allocate those costs to HIV/AIDS and other programs.

We found that CDC had not implemented a system to allocate its organization-wide indirect costs on a reasonable and consistent basis, as required by Federal accounting standards, until fiscal year (FY) 2003, even though the agency had made a commitment in 1997 to implement such a system for use in FY 2000. Instead, CDC relied on traditional allocation methodologies that resulted in overcharges and undercharges affecting almost all programs and activities. With the assistance of a consulting firm, CDC made some modifications to its allocation methods in 1998 and was able to reduce some of the overcharges and undercharges. Agency projections showed, however, that HIV/AIDS, one of CDC's largest programs and the focus for this audit was charged about $11.9 million for excessive indirect costs during FYs 2000 and 2001. These overcharges reduced funds available to the HIV/AIDS program to carry out program objectives, such as preventing the spread of HIV infection. Implementation of the indirect costing system was delayed because CDC, viewing the system developed by the consulting firm in 1999 as overly complex and difficult to maintain, contracted with a public accounting firm to evaluate and simplify the proposed system. CDC first implemented the simplified system in FY 2002, and, after evaluating the implementation and making some minor modifications, fully implemented it in FY 2003. We believe the new system represents a significant improvement by allocating indirect costs more equitably and providing accurate information on the full costs of CDC's programs and activities.

We recommend that CDC evaluate the effects of overcharging indirect costs to HIV/AIDS and its other programs to assure a correct accounting of program activities. In addition, because program funding levels and requirements may change over time, we also recommend that CDC periodically evaluate indirect costing methods to ensure a continued equitable allocation of such costs.

In its comments to our draft report, dated October 10, 2003, CDC concurred with our recommendations. CDC said it had reviewed the effects of reallocation of prior year funds and found them to be minimal. CDC also said it would periodically review its new system to ensure that indirect cost allocations remain equitable.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. Please call me if you have any questions or comments about this report, or your staff may contact Donald L. Dille, Assistant Inspector General for Grants and Internal Activities Audits, at (202) 619-1175 or email at ddille@oig.hhs.gov.

To facilitate identification, please refer to report number A-04-02-08001 in any correspondence related to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IDENTIFICATION AND ALLOCATION OF INDIRECT COSTS AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION

DECEMBER 2003
A-04-02-08001

Notices

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

This report discusses our self-initiated audit of the Centers for Disease Control and Prevention's (CDC) efforts to improve its system to charge organization-wide indirect costs to its programs.

We performed this audit to determine whether CDC had taken the actions we recommended after previous audits showed that indirect costs were not being equitably allocated to HIV/AIDS and other programs. Our principal recommendation in these previous audits was for CDC to develop new budgetary and accounting methods to identify and equitably allocate its indirect costs.

SUMMARY OF FINDINGS

The objective of our audit was to determine whether CDC had established a system to properly identify the costs of organization-wide indirect activities and equitably allocate those costs to HIV/AIDS and other programs.

Although CDC agreed in 1997 to implement by Fiscal Year (FY) 2000 a system to allocate its organization-wide indirect costs on a reasonable and consistent basis—as required by Federal accounting standards—it did not fully implement such a system until FY 2003. Instead, CDC relied on traditional allocation methodologies that resulted in overcharges and undercharges affecting almost all programs and activities. With the assistance of a consulting firm, CDC made some modifications to its allocation methods in 1998 and reduced some of the overcharges and undercharges. Agency projections showed, however, that HIV/AIDS, one of CDC's largest programs and the focus for this audit, was charged about $11.9 million for excessive indirect costs during FYs 2000 and 2001. These overcharges reduced funds available to the HIV/AIDS program to carry out program objectives, such as preventing the spread of HIV infection. Implementation of the indirect costing system was delayed because CDC, viewing the original system developed by the consulting firm in 1999 as overly complex and difficult to maintain, contracted with a public accounting firm to evaluate and simplify the proposed system. CDC first tested the simplified system in FY 2002 and, after evaluating the implementation and making some minor modifications, fully implemented it in FY 2003. Although delayed, the new system represents a significant improvement by allocating indirect costs more equitably and providing more accurate information on the full costs of CDC's programs and activities.

We recommend that CDC evaluate the effects of overcharging indirect costs to HIV/AIDS and other programs prior to implementation of the new system. In addition, because program funding levels and requirements may change over time, we recommend that CDC periodically evaluate indirect costing methods to ensure a continued equitable allocation of such costs.

In its comments to our draft report, dated October 10, 2003, CDC concurred with our recommendations. CDC said it had reviewed the effects of reallocation of prior year funds and found them to be minimal. CDC also said it would periodically review its new system to ensure that indirect cost allocations remain equitable.

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INTRODUCTION

Background

To carry out the mission of promoting health and quality of life by prevention and control of disease, injury, and disability, CDC is organized into 12 major components that focus on such areas as HIV/AIDS prevention, immunization, epidemiology, and chronic disease prevention. A component typically manages a number of programs and activities, each requiring an accurate accounting of resources and transactions. While many costs are clearly identifiable with specific programs, other costs, referred to as indirect costs, are not. Indirect costs must be allocated to specific programs in support of the principle of full cost accounting and as required by Federal accounting standards. At CDC, organization-wide indirect costs cover:

- Core business processes, such as budget formulation, accounting, procurement, grant making, information technology services, human resources, and facilities management; and

- Centrally managed services, including such expenses as rent, utilities, facilities maintenance, security services, telecommunications, and postage.

CDC has traditionally allocated indirect costs by charging each component 20 percent of its non-grant budgets and 5 percent of its grant budgets. In many instances these assessments were then adjusted based on such factors as fund availability, with little or no documentation of need or justification for the variances and exceptions. In a series of audits performed between 1992 and 1997, we pointed out that CDC's indirect cost allocations were a serious management deficiency because they were arbitrary and inconsistent. In a 1994 report[1], we explained that the methods provided "*... little assurance that costs charged to CDC's various programs accurately reflect the resources actually devoted to those programs or that the distribution of costs is consistent with the intent of Congress and the Department as expressed by the funding levels and priorities established for each program.*" Our audits showed that almost all CDC organizational components were affected by the erroneous cost allocations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether CDC had established a system to properly identify the costs of organization-wide indirect activities and equitably allocate those costs to HIV/AIDS and other programs.

[1] "Centers for Disease Control and Prevention Has Not Implemented a Charging System for Data Processing Costs" Report Number A-04-92-03505.

Scope

Our review of CDC's internal and management controls was limited to those in effect at the time of our fieldwork and applicable to the revised cost allocation methods tested in FY 2002 and implemented during FY 2003. We reviewed how CDC allocated indirect costs associated with HIV/AIDS and other programs for FYs 2000-2002.

We focused our analysis of CDC's indirect costing system on the HIV/AIDS program because our earlier audits had shown that HIV/AIDS had been overcharged more than other programs and activities.

Our audit was performed at CDC's Financial Management Office in Decatur, Georgia, from April through June 2002. Additional work was performed at CDC and our Atlanta, Georgia, and Birmingham, Alabama, field offices from July 2002 through April 2003.

We provided a draft of this report to CDC on July 23, 2003. CDC's written comments of October 10, 2003, are in Appendix C.

Methodology

To accomplish our objectives, we examined:

- Laws, regulations, and guidelines establishing requirements for budget and accounting operations by Federal agencies;

- Statements of work and detailed reports prepared by the consulting firm and the public accounting firm contracted to assist CDC in developing and implementing of indirect cost identification and allocation methods;

- CDC's Justification of Estimates for Appropriations Committees for FYs 2001, 2002, 2003; and

- CDC's appropriations bills and internal budget summaries for FYs 2000, 2001, and 2002.

In addition, we reviewed five prior reports issued by the HHS Office of Inspector General for issues related to indirect costs. (See Appendix A)

We interviewed CDC personnel to obtain an understanding of past and present methods used to identify and allocate indirect costs.

Our audit was performed in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

Although CDC agreed in 1997 to implement by FY 2000 a system to allocate its organization-wide indirect costs on a reasonable and consistent basis--as required by Federal accounting standards, it did not fully implement such a system until FY 2003. Instead, CDC relied on traditional allocation methodologies that resulted in overcharges and undercharges affecting almost all programs and activities. With the assistance of a consulting firm, CDC made some modifications to its allocation methods in 1998 and reduced some of the overcharges and undercharges. Agency projections showed, however, that HIV/AIDS, one of CDC's largest programs and the focus for this audit, was charged about $11.9 million for excessive indirect costs during FYs 2000 and 2001. These overcharges reduced funds available to the HIV/AIDS program to carry out program objectives, such as preventing the spread of HIV infection. Implementation of the indirect costing system was delayed because CDC, viewing the original system developed by the consulting firm in 1999 as overly complex and difficult to maintain, contracted with a public accounting firm to evaluate and simplify the proposed system. CDC first tested the simplified system in FY 2002 and, after evaluating the implementation and making some minor modifications, fully implemented it in FY 2003. Although delayed, the new system represents a significant improvement by allocating indirect costs more equitably and providing more accurate information on the full costs of CDC's programs and activities.

Federal Agencies Are Required to Account for the Full Costs of Programs

Statement of Federal Financial Accounting Standards Number 4 (SFFAS 4), effective October 1, 1997, establishes the standard that Federal agencies must report the "full costs" of their outputs and specifies that the full costs include both "…(1) the costs of resources consumed by the segment that directly or indirectly contribute to the output, and (2) the costs of identifiable supporting services provided by other responsibility segments within the reporting entity…"

To conform to this standard, Federal agencies must account for both the direct costs--personnel, equipment, goods and services needed to carry out a specific program--and the indirect costs applicable for that program, including the costs of general operations not readily identifiable to a particular program. While allowing flexibility as to how indirect costs are allocated among the benefiting programs, SFFAS 4 requires that the allocation methods be reasonable and consistently applied.

CDC Was Slow Implementing a New System for Identifying and Allocating Indirect Costs

CDC did not meet its commitment to implement a system to identify and allocate indirect costs by FY 2000. It did not assign costs on a reasonable and consistent basis, as required by Federal accounting standards. This resulted in inequitable charges to agency programs. In 1997, with the assistance of a consulting firm, CDC committed to implementing an improved system over a 3-year period. Full implementation of the new system was delayed, however, because CDC viewed the system initially proposed by the consulting firm as overly complex and difficult to

maintain. Accordingly, CDC contracted with a public accounting firm in 1999 to evaluate and simplify the proposed system.

CDC's Commitment to Improvements

CDC recognized that its historic method for allocating indirect costs using a percentage levied on its components was not equitable. In an agreement with the Department, the Office of Management and Budget, and Congress, CDC contracted in 1997 with a consulting firm to develop a new indirect cost allocation system. In June 1999, the firm proposed a new indirect cost allocation system for implementation in FY 2000.

CDC's Delays in Implementing the New System

CDC delayed implementing the system developed by the consulting firm out of concern that the system was overly complex and difficult to implement and maintain. The agency then contracted with a public accounting firm in 1999 to evaluate and validate the proposed methodology and recommend necessary changes. The accounting firm's final report, dated July 31, 2001, recommended several revisions to simplify and streamline the originally proposed system. For example, it recommended that the number of discrete cost pools be reduced from 27 to 20, and that the number of allocation bases be reduced from 17 to 12. (See Appendix B for a summary of cost pools and allocation bases.) CDC initially tested the new system in FY 2002. After evaluating the implementation and making minor modifications at the end of the year, CDC fully implemented it in FY 2003.

CDC's New System

While we have not audited the actual cost allocations, we have reviewed the composition and justification for each cost pool and allocation base adopted by CDC and concluded that: (1) the cost pools adequately identify all major organization-wide indirect costs in homogeneous groupings, (2) the allocation bases are from data that can be captured from existing accounting and management information systems, and (3) the allocation bases have clear relationships to the cost pools. The new system represents a significant improvement by allocating indirect costs more equitably and providing more accurate information on the full costs of CDC's programs and activities.

CDC has established a council to oversee and review the new cost identification and allocation system. The council, chaired by CDC's chief operating officer, advises the agency's Director regarding indirect cost issues.

CDC's HIV/AIDS Program Was Overcharged for Indirect Costs

Because CDC was not able to implement its new system until FY 2003, its programs continued to be overcharged and undercharged. We looked at the HIV/AIDS program and, based on CDC's own calculations, found that it had been overcharged about $11.9 million in indirect costs for FYs 2000 and 2001. These overcharges reduced available budget authority to the HIV/AIDS program, thereby curtailing the amount of resources available to carry out program objectives,

such as preventing the spread of HIV infection. Although we did not examine the extent of overcharging and undercharging throughout the agency, we would logically expect that other CDC programs experienced inaccurate charging.

Recommendations

We recommend that CDC:

1. Evaluate the effects of inaccurate charging indirect costs to HIV/AIDS and any other programs that were similarly affected prior to implementation of the new system; and

2. Periodically evaluate indirect costing methods to assure an equitable allocation of such costs. Because operations, program funding levels, and requirements change over time, longstanding methods, if unchanged, may result in an inappropriate allocation of costs.

In its October 10, 2003, comments to our draft report, CDC concurred with our two recommendations. CDC stated that it had reviewed the effects of reallocation of prior year funds and found them to be minimal. CDC also committed to periodically review its new system to ensure that indirect cost allocations remain equitable. The full text of CDC's comments is incorporated as Appendix C.

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APPENDICES

APPENDIX A

Previous Office of Inspector General Audits Addressing the Allocation of Organization-Wide Indirect Costs at CDC

Audit of Costs Charged to the Chronic Fatigue Syndrome Program at the Centers for Disease Control and Prevention (Report Number A-04-98-04226) dated May 10, 1999

Improved Budgetary and Accounting Systems at the Centers for Disease Control and Prevention (Report Number A-04-97-04217) dated March 31, 1998

Superfund Financial Activities at the Agency for Toxic Substances and Disease Registry for Fiscal Year 1995 (Report Number A-04-96-04575) dated June 2, 1997

Superfund Financial Activities at the Agency for Toxic Substances and Disease Registry for Fiscal Year 1994 (Report Number A-04-95-04550) dated September 29, 1995

Centers for Disease Control and Prevention Has Not Implemented a Charging System for Data Processing Costs (Report Number A-04-92-03503) dated March 16, 1994

APPENDIX B

Summary of Cost Pools and Allocation Bases For Organization-Wide Indirect Costs at CDC As of October 1, 2003

Indirect Cost Pool	Allocation Base
Contracts Administration	Projected Contract Dollars
Grants Administration	Projected Grant Dollars
Procurement and Grants Office Purchasing Office of the Director (OD) Property Management Central Receiving	Net Budget (Excluding Contracts/Grants)
Management Analysis Services OD/Procedure/Analysis Mail Management Order/Distribution of Publications Printing/Copying Graphics Committee Management/Panels	Net Budget (Excluding Contracts/Grants)
Financial Management Office	Net Budget (Excluding Contracts/Grants)
DHHS 1% Assessment	Gross Budget
Human Resources Management Personnel Processing Training Processing	Ceiling Full-Time Equivalents (FTEs)
Information Resources Management Information Transaction Services Data Center Telecommunications Programming Services Contract Information Technologies/Systems	 % of Information Technology Services Usage % of Mainframe Usage % of Telecommunication Lines % of Programming Services Contract Usage # of Users – FTEs/Contractors/Fellows (Total Head Count)
Design, Construction, and Management	Total Useable Square Feet
Facilities Planning and Project Management	Total Useable Square Feet
Facilities Engineering Office	Total Useable Square Feet
Rent/Utilities/Maintenance	Atlanta Square Footage Usage and All Other Direct Billing
Assessment for Services Human Resource Service Administrative Operations Non-Program Support Center	Ceiling FTEs
Postage/Miscellaneous Recurring Postage Miscellaneous Recurring Shuttle Services	Net Budget (excluding Contracts/Grants)
Security Services Contract	Total Useable Square Feet
Miscellaneous Non Recurring Department Assessment/Agency Initiatives/Crosscutting Cost	Net Budget (excluding contacts/Grants)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Centers for Disease Control
and Prevention (CDC)
Atlanta GA 30333

OCT 1 0 2003

TO: Charles J. Curtis
Regional Inspector General
For Audit Services, Region IV

FROM: Chief Operating Officer
Centers for Disease Control and Prevention

SUBJECT: Identification and Allocation of Indirect Costs to HIV/AIDS and Other Programs, Report Number A-04-08001

The Centers for Disease Control and Prevention (CDC) has reviewed the Department of Health and Human Services' Office of Inspector General (OIG) report entitled "Identification and Allocation of CDC Indirect Costs," report number A-04-08001.

CDC appreciates the acknowledgments by OIG for the efforts CDC has made to improve which demonstrate CDC's commitment to quality. OIG noted CDC's use of external consultants and its implementation of an organizational-wide indirect cost methodology for FY 2002 which was fully implemented for FY 2003. In addition, CDC was recognized for its new indirect cost system which provides accurate information on the full costs of CDC's programs and activities.

The draft report identified two specific recommendations, and CDC has the following comments in response to those recommendations.

Recommendation 1. Evaluate the effects of inaccurately charging indirect costs to HIV/AIDS and any other programs that were similarly affected. This evaluation may involve reversing the indirect charges and other steps, as necessary, to assure a correct accounting and funding of program activities.

Response: CDC concurs with this recommendation. CDC has reviewed the impact of the concerns relating to overhead allocations identified in the draft report and has determined that the effects of the reallocation of prior year funds are minimal. CDC will continue efforts to ensure that the new indirect cost system provides accurate information on the full costs of CDC's programs and activities.

Recommendation 2: Periodically evaluate indirect costing methods to ensure an equitable allocation of such costs. Because operations, program funding levels, and requirements change over time, longstanding methods, if unchanged, may result in am inappropriate allocation of costs.

Response: CDC concurs, and will periodically review the method for allocating indirect costs to ensure the allocation remains equitable.

CDC appreciates the opportunity to review and provide comments on this draft report. If your staff should have questions regarding these comments, please have them contact John Tibbs, Acting Director, CDC Financial Management Office, at telephone (404) 498-4000.

William H. Gimson, MBA