DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 10 1999

From June Gibbs Brown
Inspector General

Subject Audit of Costs Charged to the Chronic Fatigue Syndrome Program at the Centers for Disease Control and Prevention (CIN: A-04-98-04226)

To Jeffrey P. Koplan, M.D., M.P.H.
Director, Centers for Disease Control and Prevention

The attached final report provides you with the results of our audit of costs charged to the Chronic Fatigue Syndrome program by the Centers for Disease Control and Prevention (CDC) for Fiscal Years 1995 through 1998.

In written comments dated April 21, 1999, CDC generally concurred with our recommendations and identified actions that have or will be taken to fully implement the recommendations.

Please advise us within 60 days on the status of any further action taken or planned on our recommendations. If you have any questions, please call me or have your staff contact Joseph J. Green, Assistant Inspector General for Public Health Service Audits, at (301) 443-3582.

To facilitate identification, please refer to Common Identification Number A-04-98-04226 in all correspondence related to this report.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF COSTS CHARGED TO THE CHRONIC FATIGUE SYNDROME PROGRAM AT THE CENTERS FOR DISEASE CONTROL AND PREVENTION

JUNE GIBBS BROWN
Inspector General

MAY 1999
A-04-98-04226

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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Subject Audit of Costs Charged to the Chronic Fatigue Syndrome Program at the Centers for Disease Control and Prevention (CIN: A-04-98-04226)

To Jeffrey P. Koplan, M.D., M.P.H.
Director, Centers for Disease Control and Prevention

This report discusses our audit of costs charged to the Chronic Fatigue Syndrome (CFS) program by the Centers for Disease Control and Prevention (CDC). Our audit was requested by CDC officials following allegations that CDC had diverted CFS funds to other programs and had provided erroneous information to Congress regarding the scope and cost of CFS research.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our audit was to determine whether costs charged to the CFS program during Fiscal Years (FY) 1995 through 1998 were actually incurred for that program in accordance with applicable laws, regulations, and accounting standards.

SUMMARY OF FINDINGS

During FYs 1995 through 1998, CDC spent significant portions of CFS funds on the costs of other programs and activities unrelated to CFS and failed to adequately document the relevance of other costs charged to the CFS program. Specifically, of the almost $22.7 million charged to the CFS program during FYs 1995 through 1998:

- we accepted $9.8 million (43 percent) as actually incurred for program purposes;
- we could not accept $8.8 million (39 percent) because it was incurred for non CFS-related activities; and
- we could not determine the applicability of $4.1 million (18 percent) of indirect costs to the CFS program because it was not documented in sufficient detail, although it is reasonable to expect that a portion of these costs were allocable to CFS.

Although CDC is not statutorily prohibited from spending funds budgeted for CFS on other programs, it is clear that Congress expected the agency to spend the amount it budgets for CFS only on CFS.

These questionable charges resulted from deficiencies in CDC's internal control system regarding the handling of direct and indirect costs. As a result of these inappropriate charges, CDC officials provided inaccurate information to Congress regarding the use of CFS funds, and have not supported the CFS program to the extent recommended and encouraged by Congress.

Based on our audit, we are recommending that CDC officials:

1. Implement a training and certification program for managers and staff responsible for budget and accounting functions within all organizational components to ensure they are aware of requirements applicable to the use of Federal funds and understand how to properly use CDC's accounting system.

2. Establish an internal quality assurance capacity within the Financial Management Office to carry out regular assessments of CDC's policies, procedures, practices, and controls related to budget and accounting functions.

3. Continue development of systems to properly identify and allocate organizationwide indirect costs at the CDC level and begin development of similar systems to identify and allocate indirect costs at its component units based on the relative benefits provided.

In formal comments on a draft of this report, CDC generally concurred with our findings, but raised questions concerning our conclusions as to the extent that indirect costs should have been considered allocable to the CFS program. In response to those questions, additional discussion has been provided in the **Management Comments** and **OIG Response** sections of the report. The full text of CDC's comments is incorporated as Appendix B to the report.

The CDC's comments recognize the need for enhanced controls over charges at the program level. The CDC officials have already taken action to initiate the recommendations stated above and have also committed to share a comprehensive spending plan for the CFS program with the national CFS advisory committee, the Congress, and nonprofit organizations providing support services to CFS patients.

BACKGROUND

CDC MISSION AND ORGANIZATION

The CDC is a major organizational component of the Department of Health and Human Services (HHS), with the mission of promoting good health and quality of life through preventing and controlling disease, injury, and disability. The CDC serves as a national focal point for developing and applying disease prevention and control, environmental health, health promotion, and health education activities designed to improve the health of people in the United States and around the world.

WHAT IS CFS?

According to CDC, CFS is a debilitating disorder characterized by profound fatigue and lack of stamina, which is not improved by bed rest and may be worsened by physical or mental activity. The CFS may persist for years, with the nature of symptoms varying from patient to patient and fluctuating in severity from time to time. There is no definitive diagnostic test for CFS at this time, and the illness may not be recognized or may frequently be mistaken for other disorders.

CONCERNS REGARDING CDC'S USE OF CFS FUNDS

Although the causes and transmission mechanisms have never been identified, the belief that CFS was possibly viral led to placement of the program at CDC's National Center for Infectious Diseases (Center). Within the Center, the CFS program is operated by the Viral Exanthems and Herpesvirus Branch (Branch) of the Division of Viral and Rickettsial Diseases (Division).

In July 1998, the Branch Chief alleged that significant portions of the funds reported as expended for CFS research had not actually been used for that program. In brief, the Branch Chief asserted that the Division Director had diverted CFS funds and presented false information as to the actual costs of CFS research. The Branch Chief further alleged that CDC officials had knowingly provided false and misleading information to the Congress to conceal the diversion of CFS funds from their intended purpose. In August 1998, CDC management officials contacted the Office of Inspector General and requested that we perform an independent audit to assess the validity of the Branch Chief's claims.

OBJECTIVES, SCOPE, AND METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether costs charged to the CFS program during FYs 1995 through 1998 were actually incurred for that program in compliance with applicable laws, regulations, and accounting standards.

SCOPE AND METHODOLOGY

To accomplish our objective, we:

- identified and reviewed laws, regulations, and other criteria establishing requirements for budget and accounting operations by Federal agencies;
- analyzed the language in CDC's annual appropriations acts and congressional reports to determine specified funding levels for the CFS program and identify congressional concerns and suggestions regarding program activities;
- reviewed congressional testimony provided by CDC officials regarding costs of the CFS program;
- met with the Branch Chief and the Division Director to gain an understanding of CFS program history, current operations, and plans for the future as well as identify Center, Division, and Branch policies, procedures, and practices related to funding of the program;
- interviewed Center, Division, and Branch scientists and staff to discuss their involvement in the CFS program over the period of our audit, and the relationship of work performed within their particular organizational units to the CFS program; and
- examined CDC's accounting records related to the CFS program and documentation for specific transactions involving charges to the CFS program.

We met with CDC officials during the course of our field work to advise them of our tentative findings, discuss additional sources of relevant information, and explore alternative methods to strengthen their internal controls over charges at the program level.

Our review did not include a full assessment of the internal control structure related to CDC's accounting system. In lieu of a comprehensive internal control review, we

increased our substantive testing of individual transactions as necessary to assess the extent and effectiveness of those controls.

Our audit was performed in accordance with generally accepted government auditing standards. Field work was performed at CDC in Atlanta, Georgia, from August 1998 through February 1999.

AUDIT FINDINGS IN DETAIL

During FYs 1995 through 1998, CDC spent significant portions of CFS funds on the costs of other programs and activities unrelated to CFS and failed to adequately document the relevance of other costs charged to the CFS program. Specifically, of the almost $22.7 million charged to the CFS program during FYs 1995 through 1998:

- we accepted $9.8 million (43 percent) as actually incurred for program purposes;
- we could not accept $8.8 million (39 percent) because it was incurred for non CFS-related activities; and
- we could not determine the applicability of $4.1 million (18 percent) of indirect costs to the CFS program because it was not documented in sufficient detail, although it is reasonable to expect that a portion of these costs were allocable to CFS.

These questionable charges resulted from deficiencies in CDC's internal control system regarding the handling of direct and indirect costs. As a result of these inappropriate charges, CDC officials provided inaccurate information to Congress regarding the use of CFS funds and have not supported the CFS program to the extent recommended and encouraged by Congress.

CRITERIA - FEDERAL AGENCIES MUST MAINTAIN ACCOUNTABILITY OVER APPROPRIATED FUNDS

Federal laws, regulations, and other guidance establish a broad framework of accountability for financial management in agencies such as CDC. Agencies must maintain accountability for the financial results of actions taken, control over financial resources, and protection of assets.

As stated in Office of Management and Budget Circular A-127, agencies such as CDC are required to maintain financial management systems and the related internal and management controls that:

> ". . . provide complete, reliable, consistent, timely and useful financial management information on Federal Government operations to enable central management agencies, individual operating agencies, divisions, bureaus and other subunits to carry out their fiduciary responsibilities; deter fraud, waste, and abuse of Federal Government resources; and facilitate efficient and effective delivery of programs . . . ."

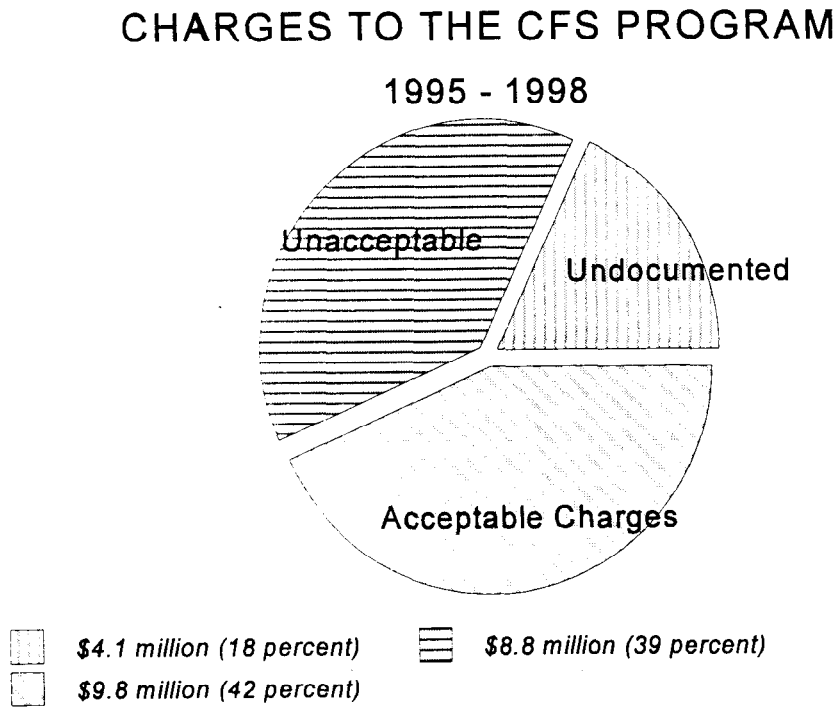
Although CDC is not statutorily prohibited from spending funds budgeted for CFS on other programs, it is clear that Congress expected the agency to spend the amount it budgets for CFS only on CFS. Since FY 1993, CDC has incorporated funding for CFS in its annual budget requests and funds for the CFS program have been included without specific identification in the CDC budget covering most of the agency's programs and activities.

During the period of our audit, CDC budgeted a total of $23.4 million for CFS research, as shown below.

Fiscal Year	CFS Funding
1995	$ 6,042,000
1996	$ 5,789,000
1997	$ 5,789,000
1998	$ 5,789,000
Total	$23,409,000

CONDITION - SOME CHARGES TO THE CFS PROGRAM WERE ACCEPTABLE, BUT MOST WERE NOT

Of the almost $22.7 million charged to the CFS program during FYs 1995 through 1998, we accepted $9.8 million as actually incurred for program purposes. We could not accept $8.8 million because it was actually incurred for other programs and activities not related to CFS; and $4.1 million was not documented in sufficient detail for us to discern its applicability to the CFS program.



Acceptable Charges to the CFS Program: $9.8 Million

In total, we accepted $9.8 million of costs as actually incurred for CFS program purposes. In addition to such items as salaries, supplies, travel, and equipment directly supporting CFS activities at CDC, this amount included $4.3 million expended for a contractor to carry out CFS research studies in Wichita, Kansas, and other locations.

Unacceptable Charges to the CFS Program: $8.8 Million

Of the charges spent on non-CFS activities, we identified:

- $5.1 million of salaries, travel, equipment, supplies, and other expenses charged as direct costs[1] of the CFS program; and

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1 Direct charges are for expenses that can be specifically identified with an individual program or activity. For example, the costs of salaries for employees working on a program, the equipment used for the program, materials, supplies, or other items specifically identifiable to a particular program should be charged as direct costs.

- $3.7 million charged to the CFS program as its share of indirect costs[2] at the CDC, Center, and Division levels.

Direct Costs: $5.1 Million

We identified $5.1 million in salaries, travel, equipment, supplies, and other costs actually incurred to benefit other programs, including:

- $4 million of costs which were not justified by the actual efforts of the organizational components from which the costs were transferred. The CDC scientists and other staff members interviewed during our audit advised us that their work was not related to CFS research.[3] For example:

  - $98,570 of data processing equipment costs were charged to the Poxvirus, Human Papillomavirus, and other Sections and transferred to the CFS program on September 28, 1995. Scientists from these units told us that none of their work had any applicability to CFS.

  - $1,649,562 of equipment, supplies, travel, and other costs were originally charged to the Division's Measles and Poliomyelitis Sections and transferred to CFS on September 30, 1996. Scientists in both those sections stated that their work could not be related in any way to the CFS program.

  - $320,000 of laboratory supplies and chemical costs were originally charged to the Respiratory and Enterovirus Branch (REVB) account and transferred to CFS on September 30, 1996. We determined from discussions with scientists from REVB that none of the ongoing laboratory research was applicable to CFS.

- $1.1 million of costs which exceeded the amounts actually incurred under the accounts from which the costs were transferred. There was no way to identify the actual nature of the claimed costs, the programs, or activities for which the

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2 Indirect charges are for expenses related to activities benefitting more than one program, such as accounting, personnel, payroll, or security.

3 During our audit, we recognized CDC's position that research into one disease may also apply to another disease, which would then justify an equitable sharing of research costs. Accordingly, we accepted transferred costs where there was any agreement among the involved scientists that research was even potentially applicable to CFS.

costs were actually incurred, or the actual relationship of the costs to CFS research. Examples of such costs include:

- $546,029 in excess of the amount actually recorded for salary and retirement costs charged to the Branch general account. This amount was transferred to the account on September 28, 1995.

- $150,507 in excess of the data processing equipment costs charged to the Branch general account, which were transferred to the CFS program on September 28, 1995.

- $41,959 of costs originally charged to the Branch general account which were transferred to the CFS program on September 30, 1997, and recorded as laboratory supplies. The amount actually represented the balance of Branch credit card charges that could not be reconciled to any particular account because CDC could not provide us with the receipts. There was no documentation from which we could determine exactly what had been purchased or to what program the costs should have been applied.

Indirect Costs - $3.7 Million

We identified $3.7 million[4] of indirect costs that should have been allocated to other CDC programs, including:

- $1.8 million charged to the CFS program, but allocable to the questionable direct costs discussed in the preceding section of our report. During FY 1997, for example, the CFS program was overcharged:

  - $67,819 for indirect costs at the Division level based on unrelated direct costs.

  - $109,932 for indirect costs at the Center level based on unrelated direct costs.

  - $142,779 for organizationwide CDC level based.on unrelated direct costs.

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4 In the absence of data needed to identify and allocate indirect costs in a more specific manner, it was

- $1.9 million charged to the CFS program based on allocations that were excessive in relation to charges made to other Division programs. During FY 1997, for example, the CFS program was charged:

  - $1.2 million for CDC level organizationwide indirect costs. However, information compiled by the CDC's Financial Management Office indicates that the CFS share of CDC indirect costs actually allocated to Center programs would have been only about $.7 million.

  - $.6 million for Division level indirect costs, even though the CFS program should have been allocated only about $.3 million for its share of these indirect costs for the operation of Division programs.

Undocumented Charges to the CFS Program: $4.1 Million

Because CDC has not developed and implemented appropriate policies, procedures, or practices to ensure that indirect costs are properly identified and consistently allocated among the benefitting programs, we cannot express an opinion on the $4.1 million balance of indirect costs charged to the CFS program. Nevertheless, it is reasonable to expect that a portion of these indirect costs were allocable to the CFS program.

CAUSE - INEFFECTIVE INTERNAL CONTROLS

The questionable charges discussed above resulted from basic deficiencies in CDC's internal control system related to both direct and indirect costs. In response to our audit work, CDC is taking action to bolster these controls.

Controls over Direct Costs

After identifying a consistent pattern where unrelated costs were transferred to the CFS program, we determined that CDC does not have adequate controls to ensure that direct costs charged at the program activity level are based upon the actual efforts of the involved personnel and the actual use of other resources. Lacking such controls, the Division Director, who generally justified the transfer of CFS costs to ensure that other division programs were sufficiently funded, was able to transfer unrelated costs to the CFS program without appropriate analysis, documentation, or justification.

The Division Director and his Associate Director for Management told us the cost transfers were based on the Division Director's knowledge of Division activities and estimates of each person's time. However, our interviews with Division scientists and other staff and our review of internal reports summarizing Division activities, showed that the Division Director consistently overstated the extent of effort devoted to CFS research.

Controls Over Indirect Costs

Similar to the direct costs area, we determined that CDC has inadequate controls to ensure that indirect costs from all organizational levels are properly identified and consistently allocated among various programs and activities. As demonstrated earlier in this report, indirect costs charged to the CFS program were generally excessive in relation to other programs and were largely undocumented.

Although CDC has long maintained formal policies and procedures addressing the allocation of organizationwide indirect costs, numerous exceptions to these policies have been made over the years. As a result, allocations of organizationwide indirect costs have been arbitrary and inconsistent, with some programs significantly overcharged while other programs were charged far less than their fair share.

Regarding indirect costs within an organizational component, such as a Center or Division, CDC has not yet developed formal policies for identifying and allocating such costs. Thus, CDC's various Centers, Divisions, and Branches are able to arbitrarily charge indirect costs to some or all of their programs, with no assurance that those charges will be reasonable and consistent.

Actions Taken by CDC to Strengthen Internal Controls

We discussed our tentative findings and conclusions with CDC officials during the course of our audit, and they concurred with the need for strengthened internal controls over charges at the program level. Further, a number of actions are now underway which we believe will significantly bolster control over the use of funds within all their organizational components.

With respect to direct costs, such as described earlier in this report, CDC officials advised us that they have limited the use of cost transfers by employees within its organizational components. Thus, cost transfers, such as were made against the CFS program, will be detected by CDC's Financial Management Office before funds are diverted for unjustified purposes.

In addition, CDC is in the process of implementing policies, procedures, and practices related to the identification and allocation of indirect costs at the CDC level. At the request of CDC, we have worked with its staff to ensure that this new system will consistently and equitably distribute CDC's organizationwide indirect costs. We understand the new system will be ready for full implementation prior to FY 2000.

EFFECT - CDC PROVIDED INACCURATE DATA TO CONGRESS AND DID NOT SPEND CFS FUNDS ACCORDING TO CONGRESSIONAL EXPECTATIONS

The questionable charges discussed above resulted in two serious effects: (1) CDC officials provided inaccurate and potentially misleading information to Congress concerning the scope and cost of CFS research activities; and (2) CDC did not spend CFS funds in a manner recommended and encouraged by Congress.

Inaccurate Data Provided to Congress

The CDC provided inaccurate and potentially misleading information to Congress concerning the scope and cost of CFS research activities. For example, during testimony provided on March 5, 1998, before the House Appropriations Committee regarding the budget request for FY 1999, the Acting Director of CDC provided testimony and data summarizing the use of CFS funds for FYs 1996 through 1998--testimony and data that we concluded was inaccurate and potentially misleading about the nature, scope, and cost of the CFS program.

CFS Funds Not Spent According to Congressional Intent

The diversion of CFS funds to other programs has adversely affected the CDC's ability to comply with congressional intent regarding CFS research. While specific funding levels are no longer mandated through CDC's annual appropriations, Congress has continued to express a strong interest in the CFS program. For example,

- In several congressional reports,[5] CDC was encouraged to enhance its laboratory studies and surveillance projects, including outreach to minority populations, children, and adolescents. These are efforts related to CFS research.

- In its July 25, 1997 report, the House Committee on Appropriations, Subcommittee on Health, Human Services and Labor, encouraged CDC to add a neuroendocrinologist to the CFS research program to enable expansion of its research efforts and pursue promising findings from other Federal agencies and the private sector.

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5 House of Representatives, Committee on Appropriations Reports 104-659 and 105-205, dated July 8, 1996, and July 25, 1997, respectively; and Senate Committee on Appropriations Report 104-368, dated September 12, 1996.

Despite congressional encouragement for these efforts, at the time of our audit, CDC had discontinued its adolescent study and had not hired a neuroendocrinologist. Internal correspondence at the Division and Branch levels indicated that delays were forced due to a "lack of available funds." Yet, we found that large portions of budgeted CFS funds had been held in reserve by the Division Director during the year, and were not released until after the deadline for obligations had passed. Thus, while important enhancements were not being implemented, more than $850,000 of FY 1998 budgeted funds were never made available to the program.

RECOMMENDATIONS

Based on our audit, we recommend that CDC officials:

- implement a training and certification program for managers and staff responsible for budget and accounting functions within all organizational components to ensure they are aware of requirements applicable to the use of Federal funds and understand how to properly use CDC's accounting system.

- establish an internal quality assurance capacity within the Financial Management Office. Among its responsibilities, this unit could carry out regular assessments of CDC's policies, procedures, practices, and controls related to budget and accounting functions.

- continue development of systems to properly identify and allocate indirect costs at the CDC level and begin development of similar systems to identify and allocate indirect costs at its organizational components based on the relative benefits provided.

Management Comments

In its formal comments on a draft of this report, CDC generally concurred with our findings that significant amounts budgeted for CFS research were actually used for other programs and activities. The CDC cited actions it has taken to implement our recommendations and also committed to share a comprehensive spending plan for the CFS program with the national CFS advisory committee, the Congress and non-profit organizations providing support services to CFS patients.

The CDC made several editorial suggestions that it believed would improve the balance of the report and disagreed with a statement in the draft report regarding the timing of the allegations regarding CFS funds.

The CDC also raised questions concerning our determination as to the extent that indirect costs should have been considered allocable to the CFS program. The CDC argued that ". . . the auditors were able to allocate indirect costs to non-CFS direct costs and were able to determine excessive amounts allocated to the CFS program. Since the auditors could determine those indirect costs not associated with CFS, we believe that CFS indirect costs are also determinable. Specifically, we believe that $4.1 million reported as undocumented costs should be accepted as indirect cots related to CFS . . . ." The CDC added that ". . . a CDC-wide rate of 20 percent on **non-grant** funds was consistently applied to CFS. Therefore, we believe that the auditors should accept CDC-wide indirect charges to CFS based on the historical allocation technique."

OIG Response

We are pleased that CDC recognizes the need for enhanced controls at the program level.

Where we believe they would improve the fairness or accuracy of our presentation, we have incorporated CDC's editorial suggestions into our final report.

We do not agree with CDC's arguments that the $4.1 million reported as undocumented costs should be accepted as indirect costs related to CFS. Our identification of $3.7 million in excessive indirect costs and indirect costs allocable to non-CFS direct costs has no effect on the remaining $4.1 million of indirect costs which remain questionable because they are undocumented. The CDC has an allocation system scheduled to be implemented in FY 2000 that will identify CDC-wide indirect costs. Without such a system, we cannot determine how much of the $4.1 million is properly charged to CFS. The fact that CDC has historically charged 20 percent on non-grant funds is irrelevant unless CDC can demonstrate that 20 percent was the appropriate rate.

APPENDICES

Centers for Disease Control and Prevention
National Center for Infectious Diseases
CIN: A-04-98-04226

Chronic Fatigue Syndrome Costs - FYs 1995 through 1998

	Total CFS Costs	Accepted	Not Allocable to CFS	Not Supported
Personnel	$4,699,580	$2,870,615	$1,828,965	
Travel	221,460	125,283	96,177	
Transportation	11,552	6,133	5,419	
Communication	330	0	330	
Printing	38,533	34,013	4,520	
Contracts, Agreements, Other	6,945,917	5,573,566	1,372,351	
Supplies	1,188,661	350,155	838,506	
Equipment	1,744,798	814,100	930,698	
Subtotal	$14,850,831	$9,773,865	$5,076,966	
DVRD OD Overhead	$1,311,065	0	$773,385	$537,680
DVRD Biometrics (Computer Support)	342,829	0	132,768	210,061
NCID Overhead	1,956,083	0	608,948	1,347,135
CDC Overhead	4,183,559	0	2,187,854	1,995,705
Subtotal	$7,793,536	0	$3,702,955	$4,090,581
Total CFS Costs:	$22,644,367	$9,773,865	$8,779,921	$4,090,581

Centers for Disease Control and Prevention
National Center for Infectious Diseases
CIN: A-04-98-04226

Chronic Fatigue Syndrome Costs - FY 1995

	Total CFS Costs	Accepted	Not Allocable to CFS	Not Supported
Personnel	$2,130,693	$1,533,392	$597,301	
Travel	70,636	25,961	44,675	
Transportation	4,726	2,727	1,999	
Communication	330	0	330	
Printing	23,784	23,065	719	
Contracts, Agreements, Other	1,391,260	1,255,801	135,459	
Supplies	321,607	169,230	152,377	
Equipment	320,561	94,342	226,219	
Subtotal	$4,263,597	$3,104,518	$1,159,079	
DVRD OD Overhead	0			
DVRD Biometrics (Computer Support)	0			
NCID Overhead	$563,448	0	$153,176	$410,272
CDC Overhead	1,214,955	0	640,382	574,573
Subtotal	$1,778,403	$0	$793,558	$984,845
Total CFS Costs:	$6,042,000	$3,104,518	$1,952,637	$984,845

Centers for Disease Control and Prevention
National Center for Infectious Diseases
CIN: A-04-98-04226

Chronic Fatigue Syndrome Costs - FY 1996

	Total CFS Costs	Accepted	Not Allocable to CFS	Not Supported
Personnel	$780,119	$376,048	$404,071	
Travel	24,968	24,968		
Transportation	28	28		
Communication				
Printing	8,750	8,750		
Contracts, Agreements, Other	1,916,715	1,016,715	900,000	
Supplies	600,863	6,301	594,562	
Equipment	732,119	257,119	475,000	
Subtotal	$4,063,562	$1,689,929	$2,373,633	
DVRD OD Overhead	$200,000	0	$75,676	$124,324
DVRD Biometrics (Computer Support)	77,089	0	22,887	54,202
NCID Overhead	361,698	0	211,277	150,421
CDC Overhead	1,164,355	0	786,846	377,509
Subtotal	$1,803,142	$0	$1,096,686	$706,456
Total CFS Costs:	$5,866,704	$1,689,929	$3,470,319	$706,456

Centers for Disease Control and Prevention
National Center for Infectious Diseases
CIN: A-04-98-04226

Chronic Fatigue Syndrome Costs - FY 1997

	Total CFS Costs	Accepted	Not Allocable to CFS	Not Supported
Personnel	$704,258	$510,935	$193,323	
Travel	66,549	28,255	38,294	
Transportation	1,407	1,407		
Communication				
Printing	3,894	93	3,801	
Contracts, Agreements, Other	2,259,661	2,006,083	253,578	
Supplies	84,305	42,346	41,959	
Equipment	345,202	172,344	172,858	
Subtotal	$3,465,276	$2,761,463	$703,813	
DVRD OD Overhead	$529,488	0	$330,207	$199,281
DVRD Biometrics (Computer Support)	98,001	0	31,184	66,817
NCID Overhead	541,257	0	109,932	431,325
CDC Overhead	1,164,355	0	603,583	560,772
Subtotal	$2,333,101	0	$1,074,906	$1,258,195
Total CFS Costs:	$5,798,377	$2,761,463	$1,778,719	$1,258,195

Centers for Disease Control and Prevention
National Center for Infectious Diseases
CIN: A-04-98-04226

Chronic Fatigue Syndrome Costs - FY 1998

	Total CFS Costs	Accepted	Not Allocable to CFS	Not Supported
Personnel	$1,084,510	$450,240	$634,270	
Travel	59,307	46,099	13,208	
Transportation	5,391	1,971	3,420	
Communication				
Printing	2,105	2,105		
Contracts, Agreements, Other	1,378,281	1,294,967	83,314	
Supplies	181,886	132,278	49,608	
Equipment	346,916	290,295	56,621	
Subtotal	$3,058,396	$2,217,955	$840,441	
DVRD OD Overhead	$581,577	0	$367,502	$214,075
DVRD Biometrics (Computer Support)	167,739	0	78,697	89,042
NCID Overhead	489,680	0	134,563	355,117
CDC Overhead	639,894	0	157,043	482,851
Subtotal	$1,878,890	$0	$737,805	$1,141,085
Total CFS Costs:	$4,937,286	$2,217,955	$1,578,246	$1,141,085

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control
and Prevention (CDC)

Memorandum

Date APR 21 1999

From Director
Centers for Disease Control and Prevention

Subject Audit of Costs Charged to the Chronic Fatigue Syndrome Program at the Centers for Disease Control and Prevention (CIN:A-04-98-04226)

To June Gibbs Brown
Inspector General

The Centers for Disease Control and Prevention (CDC) appreciates the opportunity to review and provide comments on the Office of Inspector General Draft Report, "Audit of Costs Charged to the Chronic Fatigue Syndrome (CFS) Program," and your expeditious response to CDC's request for an audit.

Although the audit concludes that CDC spent portions of CFS funds on other programs and provided incorrect information to Congress concerning CFS program costs, the funds that were not expended for CFS were spent in extremely important disease areas, such as measles, poliomyelitis, and human papillomavirus. While CDC is not legally prohibited from spending funds budgeted for CFS on other programs, we acknowledge the importance of complying with the intent of Congress and providing correct information to Congress.

In response to your recommendations, the following actions have or will be completed:

- Share a CFS spending plan for this year with the CFS Advisory Committee, Congress, the nonprofit organizations providing support services to CFS patients, and eventually the general public.

- Implement a training and certification program for managers and staff responsible for budget and accounting functions within all organizational components to ensure awareness of statutory and regulatory requirements for Federal funds and understanding of how to use CDC's accounting system properly.

- Establish an internal review capacity to carry out regular assessments of CDC's policies, procedures, practices, and controls related to budget and accounting functions.

- Develop a new allocation system for identification of CDC-wide indirect costs (implementation to be completed by fiscal year [FY] 2000). In addition, develop systems to identify and allocate indirect costs at lower organizational components based on the relative benefits provided.

The following specific comments are provided for your consideration regarding the CFS audit and Report recommendations as they relate to specific sections in the Report:

EXECUTIVE SUMMARY

SUMMARY OF FINDINGS

The Executive Summary indicates that $4.1 million was not documented in sufficient detail to discern its applicability to the CFS program. However, the "Executive Summary" does not indicate that these costs were indirect costs and does not contain the conclusion made later in the Report that "it is reasonable to expect that a portion of these indirect costs were allocable to CFS," as stated under the heading "Undocumented Changes to the CFS Program: $4.1 million." This omission from the Executive Summary could be misleading, and we request that this statement be included in the "Executive Summary, Summary of Findings."

BACKGROUND

CONCERNS REGARDING CDC'S USE OF CFS FUNDS

The Report does not mention that in August 1996, a six-member external peer review group, led by Professor Anthony Komaroff of Harvard University, conducted a thorough review of all aspects of the CFS Program at CDC. The review group was pleased with the progress of CDC's CFS program and made specific recommendations for future efforts, including continued studies of the possible role of human herpesvirus 6, Borna disease virus, and other microorganisms in CFS. The peer group recommendations support the view that the funding and study of several diseases could provide insight into the cause of another disease. The audit report does not acknowledge that several CDC officials voiced their support for the investigation of several diseases that might provide further knowledge of CFS.

The time line in the second paragraph is not correct. CDC requests that the first two sentences of this paragraph be deleted. During the April 1998 meeting of the Chronic Fatigue Syndrome Coordinating Committee (CFSCC), the Branch Chief made no allegations concerning the use of CFS funds. On July 21, 1998, when CDC became aware of the allegations, CDC immediately contacted the Inspector General to request this review.

AUDIT FINDINGS IN DETAIL

CONDITION–SOME CHARGES TO THE CFS PROGRAM WERE ACCEPTABLE, BUT MOST WERE NOT

In the Report, all indirect costs were classified as either unacceptable or undocumented. However, indirect costs that were assessed by CDC, the Center, Division, and Branch were necessary to operate the CFS program. The auditors were able to allocate indirect costs to nonCFS direct costs and were able to determine excessive amounts allocated to the CFS program. Since the auditors could determine those indirect costs not associated with CFS, we believe that CFS indirect costs are also determinable. Specifically, we believe that $4.1 million reported as undocumented costs should be accepted as indirect cost related to CFS. Failure to recognize indirect costs significantly understates the actual CFS costs incurred.

For a ten-year period through FY 1997, a CDC-wide rate of 20 percent on non-grant funds was consistently applied to CFS. Therefore, we believe that the auditors should accept CDC-wide indirect charges to CFS based on the historical allocation technique.

We appreciate the opportunity to provide comments on this Report. If you should have questions regarding these comments, please contact Ms. Virginia Bales, Deputy Director for Program Management, CDC. Ms. Bales may be contacted at telephone (404) 639-7000.

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