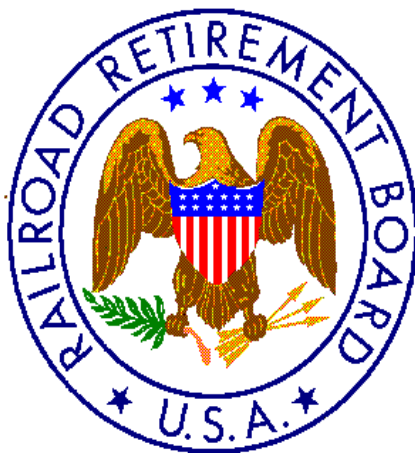


OFFICE OF INSPECTOR GENERAL

Audit Report

**Railroad Retirement Board Did Not Calculate
Reimbursed Medicare Costs In Accordance With
Federal Requirements**

**Report No. 16-10
August 22, 2016**



RAILROAD RETIREMENT BOARD

EXECUTIVE SUMMARY

Background

The Railroad Retirement Board (RRB) performs services on behalf of Medicare and is reimbursed by the Centers for Medicare and Medicaid Services (CMS) based on an interagency agreement. This interagency agreement and Office of Management and Budget (OMB) Circular A-87 (A-87) require the development of a Medicare cost allocation plan as support for this reimbursement.¹ The Office of Inspector General conducted an audit of the RRB's cost allocation plans for Medicare. The objective was to determine if the RRB's cost allocation plan and Medicare reimbursement calculations were accurate and supported in accordance with federal requirements.

Key Findings

Our audit determined that controls were not adequate to ensure the RRB's cost allocation plans and Medicare reimbursement calculations were accurate and supported in accordance with federal requirements. Further, the RRB's Medicare cost allocation policies and procedures were not effective in preventing errors. Labor costs were reimbursed based on management's professional judgment and indirect costs had not been formally approved by CMS. These weaknesses resulted in unsupported Medicare direct costs totaling approximately \$30.4 million and unsupported indirect costs ranging from \$9.5 million to \$33.8 million for fiscal years 2010 through 2014.

Over reimbursements may be offset to some extent after RRB and CMS implement a compliant direct labor cost system, establish an indirect cost rate, and determine the allowability of indirect costs. Final determination of the accurate reimbursable Medicare costs may result in violations of the Purpose Statute and Antideficiency Act.

Key Recommendations

In total, we made 26 detailed recommendations to RRB management. The key recommendations are related to:

- determining the allowable Medicare program costs and adjusting the prior reimbursements as appropriate;
- working with CMS to update the Medicare interagency agreement and adopt A-87 as an RRB agency requirement;
- implementing an OMB compliant direct labor cost system; establishing a CMS approved Medicare indirect cost rate; and determining allowable indirect costs; and
- the reporting of any Purpose Statute and Antideficiency Act violations identified pursuant to OMB Circular A-11.²

¹ OMB Circular No. A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (Washington D.C.: May 10, 2004). A-87 was relocated to 2 Code of Federal Regulations (CFR) Part 225 (effective August 31, 2005). OMB has consolidated and streamlined its guidance located at 2 CFR Part 200.

² OMB Circular No. A-11, *Preparation, Submission, and Execution of the Budget* (Washington D.C.: June 2015).

Management's Response & Our Comments

RRB management concurred with 10 recommendations and did not concur with 16 recommendations. Further, while concurring with recommendations 1 and 5, management's response raised concern because the estimated completion timeframes are unreasonable and increase the risk of inaccurate reimbursements from CMS in the future.

Such significant nonconcurrence is of concern and, as such, we met with knowledgeable RRB staff to discuss management's response to our draft report. We had previously provided detailed explanations to agency questions by phone and email and held ongoing focused discussions to resolve differences of understanding as they occurred and to obtain mutual concurrence on our findings and recommendations. During this meeting, we expressed our concerns about inaccuracies in management's responses to the draft report. This information was communicated to agency management and no revisions were made to its written responses.

Fundamentally, RRB and RRB OIG disagree on the applicability of and the RRB's compliance with A-87. In its written comments, RRB states it is in compliance with A-87, using a multiple allocation base method. The multiple allocation base method is to be used when an agency's indirect costs benefit its major functions in varying degrees. While there are elements of RRB's indirect cost allocation that are similar to the multiple allocation base method, for example, the use of program cost groupings, there are notable differences including the lack of CMS preapproved A-87 compliant allocation rates for each indirect cost grouping evidencing the proportional benefit and the use of an unequitable direct cost distribution base. During the course of our audit, RRB never mentioned or presented documentation supporting their use of the multiple allocation base method and first identified the method in its written response to our draft report. We requested documentation from RRB to support its written comments that RRB was in compliance with A-87 in determining direct costs and uses a multiple allocation base method for indirect costs. RRB replied that it did not have any additional documentation to provide. Because of the differences between what A-87 defines as the multiple allocation base method and how RRB is allocating indirect costs, we do not believe its indirect cost allocation is in compliance with A-87.

Further, for direct costs, A-87 requires specific documentation and/or an approved system dependent upon if an employee is expected to work on a single cost objective or multiple cost objectives. For example, A-87 requires salaries to be supported by monthly signed personnel activity reports, a [CMS] approved statistical sampling system or other substitute system, and semi-annual employee signed certifications; none of which were completed by RRB. RRB relies on management's judgement to determine direct cost reimbursements from CMS. Throughout this report, we identify numerous instances of noncompliance including the use of preestablished, not actual after-the-fact, employee profiles to claim salaries and benefits costs, a lack of monthly signed personnel activity reports, and the nonexistence of employee signed certifications. The accuracy of direct costs is imperative to the determination of correct indirect costs. As a result of these weaknesses and others identified in this report, RRB may have received reimbursements, particularly for indirect costs, that exceeded amounts allowable under A-87.

During discussions with OIG staff, RRB also asserted that compliance with A-87 was not required but instead stated that the circular was only considered guidance. The interagency agreement that controls the cost reimbursements states that “charges will be based on actual allowable costs as defined in the General Services Administration’s Financial Management Code 74-4”, which was reissued in 1981 as OMB Circular A-87 and codified as 2 CFR Part 225 in 2005. Thus, compliance with A-87 is required under the terms of the interagency agreement.

Generally, RRB nonconcurred with recommendations that would require retroactive assessment of the accuracy of reimbursements received from CMS in compliance with the applicable interagency agreement or to address the examples of noncompliance with A-87 discussed throughout this report. On average, the RRB receives approximately \$13.8 million for direct and indirect costs from CMS, which excludes the Specialty Medicare Administrative Contractor (SMAC) contract costs. The SMAC costs of approximately \$19.5 million per year are also reimbursed by CMS to RRB. All Medicare costs claimed are detailed in the RRB’s cost allocation plan. In order to assure the accuracy of prior and future reimbursements, RRB should take all necessary steps to implement these recommendations.

The full text of management’s response is included in this report as Appendix I.

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INTRODUCTION

This report presents the results of the Office of Inspector General's (OIG) audit of the Railroad Retirement Board's (RRB) cost allocation plans for Medicare.

Background

The RRB is an independent agency in the executive branch of the federal government. The RRB administers the retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act and the Railroad Unemployment Insurance Act. These programs provide income protection during old age and in the event of disability, death, temporary unemployment, or sickness. During fiscal year 2015, the RRB paid approximately \$12.3 billion in retirement, survivor, unemployment, and sickness benefits to approximately 583,000 beneficiaries.

Railroad Medicare

In May 1966, the Social Security Administration delegated authority to the RRB to administer certain provisions of the Medicare program for Qualified Railroad Retirement Beneficiaries (QRRB) and active Railroad employees. These provisions included enrollment, premium collection, and selection of a carrier to process Medicare Part B claims. The enactment of Public Law 92-603 on October 30, 1972 amended the Social Security Act and granted the RRB jurisdiction over all QRRBs that were receiving benefits from both the RRB and the Social Security Administration. As of September 2015, the RRB had approximately 475,000 QRRBs enrolled in Railroad Medicare, of which approximately 96 percent enrolled in Part B of the program.

Railroad Retirement Board's Medicare Cost Allocation Plan

The RRB performs Medicare program related work that otherwise would have been performed by the Centers for Medicare and Medicaid Services (CMS) and is authorized by law to be reimbursed for this work. This Medicare work is performed by various RRB bureaus, both directly and indirectly.

In July 1983, the RRB entered into an interagency agreement with CMS in which the two agencies approved a cost allocation plan.³ In April 1991, the interagency agreement was revised to authorize annual reimbursement of the expenses incurred by the RRB administering the Medicare Part B program. In July 2004, the interagency agreement was modified to reflect work performed under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.⁴

³ In September 2001, the Health Care Financing Administration (HCFA) became known as the Centers for Medicare and Medicaid Services (CMS).

⁴ Public Law 108-173, December 8, 2003.

The Bureau of Fiscal Operations (BFO) is responsible for preparing the agency’s annual Medicare cost allocation plan, which includes establishing a compliant methodology for allocating both direct and indirect administrative costs. The cost allocation plan is intended to provide details and explain the various calculations used to determine the costs to be reimbursed.

In fiscal year 2014, total RRB agency costs were \$150.5 million of which \$99.6 million represented labor costs and \$50.9 million represented agency contracts and non-labor indirect costs. In fiscal year 2014, total reimbursements from CMS totaled \$35 million, or approximately 23 percent of total agency costs.⁵ Table 1 below details the fiscal year 2014 Medicare costs reimbursed by CMS.

Type	Amount (in millions)
Medicare Contracts	\$20.4
Medicare Parts B, C, & D Direct Labor	6.4
Medicare Parts B, C, & D Indirect	8.2
Medicare Part A Direct & Indirect	2.8
Total Medicare Program Costs	\$35.0

The RRB must establish the cost allocation plan and the Medicare administrative costs are to be reimbursed by CMS in accordance with the interagency agreement and OMB Circular A-87 (A-87).⁶ The RRB’s interagency agreement with CMS requires that charges for services provided by the RRB will be based on actual, allowable costs as defined in A-87.⁷

OMB Circular A-87

Circular A-87 establishes principles and standards for allowable cost reimbursement determinations between governmental units. Reimbursable costs are generally either direct or indirect costs. Circular A-87 states that a cost is allocable to a particular cost objective if the goods or services involved are chargeable or assignable to such cost objective in accordance with relative benefits received.⁸

⁵ RRB received \$32.3 million through a direct reimbursement and \$2.8 million through the RRB’s financial interchange. The financial interchange coordinates the portion of railroad retirement annuities that is equivalent to social security benefits with the social security system.

⁶ OMB Circular No. A-87, *Cost Principles for State, Local, and Indian Tribal Governments* (Washington, D.C.: May 10, 2004).

⁷ Federal Management Circular 74-4 was reissued in 1981 as OMB Circular A-87 and codified as 2 CFR Part 225 in 2005. OMB has consolidated and streamlined its guidance located at 2 CFR Part 200.

⁸ A “cost objective” is a function, organizational subdivision, contract, grant, or other activity for which cost data are needed and for which costs are incurred.

Circular A-87's implementation guide directs agencies to adopt A-87 and issue implementing regulations.⁹ Once adopted and implemented within federal agency regulations, A-87 has the force and effect of law.

Circular A-87 defines allocable costs as being direct or indirect and provides a uniform approach for determining allowability of such costs. Direct costs are those that can be identified specifically with a particular final cost objective, for example, salaries and wages. Indirect costs are those that have been incurred for common or joint purposes and cannot be readily identified with a final cost objective. After direct costs have been assigned to activities as appropriate, the remaining allowable indirect costs are allocated to benefitted cost objectives. A cost may not be allocated as an indirect cost if any other cost incurred for the same purpose, in like circumstances, has been assigned as a direct cost.

Direct Costs

According to A-87, when employees work on multiple activities or cost objectives, a distribution of their salaries or wages will be supported by personnel activity reports or equivalent documentation that accounts for the total activity for which the employee is compensated, unless a statistical sampling system or other substitute system that produces quantifiable measures of employee effort has been approved by the responsible federal agency.¹⁰ Circular A-87 states that personnel activity reports or equivalent documentation must reflect an after-the-fact distribution of actual activity and account for the total activity for which each employee is compensated. The pay period based activity reports must be prepared at least monthly and signed by the employee. Budget estimates or other distribution percentages determined before the services are performed do not qualify as support for charges to federal awards but may be used for interim accounting purposes. This documentary support is required where employees work on an indirect cost activity and a direct cost activity.

Where employees are expected to work on a single cost objective, certifications that the employee worked solely on that program for the period covered will be prepared at least semi-annually and signed by the employee or supervisory official having direct knowledge of the work performed by the employee.

Indirect Costs

Circular A-87 states that all departments or agencies of the governmental unit desiring to claim indirect costs under federal awards must prepare and certify an indirect cost rate proposal and related documentation to support those costs and ensure they are allowable and allocated in accordance with applicable requirements. An indirect cost

⁹ Regulations applicable to CMS are included in the following: U.S. Department of Health and Human Services, *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, ASMB C-10 (Washington D.C.: April 8, 1997).

¹⁰ According to ASMB C-10, a personnel activity report is a timesheet or log maintained by the employee that accounts for 100 percent of their time.

rate proposal is the documentation prepared by a governmental unit to substantiate its request for the establishment of an indirect cost rate. An indirect cost rate is used to determine, in a reasonable manner, the proportion of indirect costs each program should bear.¹¹ Circular A-87 states that no cost allocation plan or indirect cost rate shall be approved by the federal government unless the plan or rate proposal has been certified and signed on behalf of the governmental unit by an individual at a level no lower than Chief Financial Officer. Where a certified proposal has not been submitted in accordance with the requirements, the responsible federal agency may either disallow all indirect costs or unilaterally establish such a plan or rate.

Circular A-87 provides an alternative method for allocating indirect costs. Under the simplified method, where the recipient agency's major functions benefit from its indirect costs to approximately the same degree, the allocation of indirect costs may be accomplished by (1) classifying the agency's total costs for the base period as either direct or indirect and (2) dividing the total allowable indirect costs by an appropriate base that will result in an equitable distribution of costs.¹² Under the simplified method, the resulting indirect cost rate is expressed as the percentage of the total amount of allowable indirect costs to the base selected, exclusive of any extraordinary or distorting expenditures.

Alternately, under the uniform method, a standard rate may be applied to determine indirect costs. Under this method, a standard indirect cost allowance equal to ten percent of the direct salary and wage cost of providing the service (excluding overtime, shift premiums, and fringe benefits) may be used in lieu of determining the actual indirect costs of the service.

Fiscal Law

The Antideficiency Act is codified in several sections of title 31 of the United States Code (USC) including 31 USC 1341(a), 1342, 1349-1351, 1511(a), and 1512-1519. The Purpose Statute is codified in 31 USC Section 1301(a). The purpose of these statutory provisions is to enforce Constitutional powers of Congress for the purpose, time, and amount of expenditures made by the federal government. Key provisions of the Antideficiency Act and Purpose Statute include:

- 31 USC Section 1301(a): commonly known as the Purpose Statute, states "appropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided by law." Violations of this statute can be resolved by deobligating those amounts charged to the wrong appropriation and obligating the amounts to an appropriation available for that purpose. If an

¹¹ The rate can be predetermined based on an estimate of the costs to be incurred during the period. The predetermined rate negotiated for indirect costs should be for a period of two to four years and should be the norm in those situations where the cost experience and other pertinent facts available are deemed sufficient to enable the parties involved to reach an informed judgment as to the probable level of indirect costs during the ensuing accounting periods.

¹² A multiple allocation base method may also be used where an agency's indirect costs benefit its major functions in varying degrees.

agency is not able to resolve the Purpose Statute violation, then it violates the Antideficiency Act.

- 31 USC Section 1341(a): prohibits officers and employees of the federal government from making or authorizing an expenditure or obligation that exceeds an amount available in an appropriation or fund for the expenditure or obligation.
- 31 USC 1351 and 1517(b): require the agency head to immediately report applicable violations of the Antideficiency Act to the President and Congress. OMB Circular A-11 provides instructions for reporting Antideficiency Act violations to the President, the Congress, and Comptroller General.¹³ In addition to the reporting requirements, violations can result in penalties on agency officials responsible for the actions that resulted in the violation.

Strategic Goal

This audit addresses the RRB's strategic goal of stewardship of agency resources that ensures funds appropriated for agency operations are spent for their intended purposes.

Objective

The objective of the audit was to determine if the RRB's cost allocation plans and Medicare reimbursement calculations are accurate and supported in accordance with federal requirements.

Scope

Our audit scope included Medicare costs reimbursed for fiscal years 2010 through 2014, as disclosed in the RRB's annual Medicare cost allocation plan. This included the RRB's processes associated with developing and supporting the costs claimed in the plans. Our audit focused on Medicare direct and indirect costs, as contract costs are not impacted by the RRB's cost allocation plan.

Methodology

To accomplish the audit objective, we:

- identified and reviewed applicable laws and regulations;
- identified and reviewed applicable agency policy and procedures;
- interviewed key RRB management and staff;
- conducted walkthroughs at RRB headquarters in Chicago, Illinois;
- identified and evaluated agency processes for determining direct and indirect costs;

¹³ OMB Circular No. A-11, *Preparation, Submission, and Execution of the Budget* (Washington D.C.: June 2015).

- identified and tested cost allocation controls and transactions, including employee profiles;
- analyzed the cost allocation plan supporting documentation and cost accounting system reports to determine A-87 compliant estimates of indirect costs;
- obtained and analyzed employee profiles and applicable supporting documentation; and
- conducted RRB field office site visits at 10 district offices and interviewed 44 RRB Field Service employees, as shown in Table 2 below.

Table 2: OIG Interviews Conducted at District Offices – September 2015				
Location	Number of Employees Interviewed by Position			
	Network/District Manager	Claims and Program Representative	Claims Representative	Other ¹
Bellevue, Washington	1	1	1	
Boston, Massachusetts	1			2
Buffalo, New York	1	1	3	
Chicago, Illinois	1	1	1	
Cleveland, Ohio	1	1	1	1
Covina, California	1	2	4	
Denver, Colorado	1		3	
Fort Worth, Texas	1	1	4	
Jacksonville, Florida	1	2	3	
Scranton, Pennsylvania	1		2	
Subtotal	10	9	22	3
Total of Employees Interviewed:	44			

¹Includes two claims representatives in training and one office automation assistant.

Our analysis provided audit coverage consistent with our objective and was designed based on knowledge and assumptions acquired during our audit planning and fieldwork. These specific assumptions included that:

- Medicare contracts were excluded from direct and indirect costs;
- RRB’s indirect labor and non-labor costs were incurred equally across each major program and cost objective;
- RRB’s indirect labor and non-labor costs were potentially unallowable as these costs had not been reviewed and approved by CMS;

- RRB's cost accounting system profile percentages were accurate even though they were only determined based on management's judgment;
- direct labor was the most appropriate cost allocation base; and
- OMB's standard indirect cost rate and simplified method were appropriate cost allocation methods for the RRB.

Our testing methodology also considered the risks inherent with unreliable data and the availability of corroborating evidence in the form of source documents, as recommended by the U.S. Government Accountability Office. We determined that computer processed data was sufficiently reliable for the testing purposes of this audit by comparing our data with supporting corroborating documents.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

We conducted our fieldwork from April 2015 through December 2015 at RRB headquarters in Chicago, Illinois and at ten selected RRB district offices. The ten district offices visited were Bellevue, Washington; Boston, Massachusetts; Buffalo, New York; Chicago, Illinois; Cleveland, Ohio; Covina, California; Denver, Colorado; Fort Worth, Texas; Jacksonville, Florida; and Scranton, Pennsylvania.

RESULTS OF AUDIT

Our audit determined that controls were not adequate to ensure the RRB's cost allocation plans and Medicare reimbursement calculations were accurate and supported in accordance with federal requirements. Further, we determined that:

- the RRB did not fully comply with the requirements of its interagency agreement and ensure that reimbursed Medicare administrative costs were reasonable, necessary, and determined in accordance with A-87;
- Medicare direct labor costs were reimbursed based on management's professional judgment and indirect costs were not approved by CMS; and
- the RRB's Medicare cost allocation policies and procedures were not effective in preventing plan calculation errors.

Noncompliance with A-87 regulations resulted in the development of an inappropriate Medicare cost allocation methodology and an annual direct and indirect program cost reimbursement that was unsupported and significantly disproportionate when compared with OMB's allowable methods, ultimately impacting funding availability and financial reporting. These weaknesses resulted in unsupported Medicare direct cost reimbursements totaling \$30.4 million and unsupported indirect cost reimbursements ranging from \$9.5 million to \$33.8 million for fiscal years 2010 through 2014. These over reimbursements may be partially offset after the RRB and CMS implement a compliant direct labor cost system, establish an indirect cost rate, and determine the allowability of indirect costs. Final determination of the accurate reimbursable Medicare costs may result in violations of the Purpose Statute and Antideficiency Act.

The details of the audit findings and recommendations for corrective action follow. The full text of management's responses is included in Appendix I.

Reimbursed Direct Labor Costs Were Not Supported

Several weaknesses exist in the RRB's determination of reimbursement for direct costs from CMS. First, RRB uses preestablished employee profiles supported by management's professional judgment to estimate the Medicare direct labor costs. In addition, RRB does not maintain personnel activity reports or equivalent documents, or obtain signed certifications from those working solely on Medicare, as required by OMB. These unsupported direct labor costs were reported in the agency's cost allocation plans and represented salaries and benefits totaling approximately \$30.4 million for fiscal years 2010 through 2014. In addition, indirect cost calculations are dependent on the accuracy of the total direct costs.

While some employee profiles indicated an allocation of 100 percent of their time to Medicare, other RRB employees are allocated a portion of their time to Medicare based on their job description, regardless of the work they actually performed. For instance,

Field Service used the same profile for all of their Network/District Managers, Claims Representatives, and Claims and Program Representatives.

In order to support its direct cost reimbursement, RRB relies on preestablished employee profiles. Each profile consists of multiple cost activity codes that the RRB uses to allocate all of the employee's direct labor cost across all of RRB's program activities. Table 3 shows the employee profile of a Claims Representative in which 7.37 percent of the employee's time would be allocable to Medicare activity and reimbursed by CMS. The remainder of the employee's time is allocated to other RRB activities such as processing retirement, unemployment and sickness applications and claims.

Table 3: Claims Representative's Employee Profile		
Cost Activity Code	Description	Percent
RA	Retirement – Processing Applications	40.75
RR	Retirement – Maintenance of Beneficiary Rolls	28.09
UU	Unemployment Insurance – Processing UI Applications and Claims	11.36
RM	Retirement – Medicare	7.37
XX	Agency Indirect	6.48
US	Unemployment Insurance – Processing SI Applications and Claims	5.95
Total		100.00

RRB employee profiles were initially developed during the 1990s by an agency workload committee but have not been validated with a measured workload time study since that time. While employee profiles can be updated as needed by management, and a sampling of the profiles occurs annually, the last major change occurred in 2008.

As shown in Table 4, according to the employee profiles used for all field service employees, each Claims Representative across the country would work approximately 35 minutes per day on Medicare and be reimbursed for this time by CMS.

Table 4: RRB Field Service Medicare Employee Profiles		
Type	Medicare Percent Per Day	Medicare Minutes Per Day
Network/District Managers	5.32	26
Claims Representatives	7.37	35
Claims and Program Representatives	7.5	36

The RRB's Medicare program operations and field service functions have changed significantly since inception of the cost allocation plan. In applying its methodology, the RRB did not consider any variances such as geography or workload. During our interviews of 44 RRB field office staff across 10 district offices, the majority of the employees reported to us that they conducted almost twice as much Medicare work than reported in the employee profiles and that economic events such as mass unemployment claims in response to railroad layoffs could impact field office workload. RRB management and staff working in the field offices indicated that they work on multiple program activities and the amount of work conducted varied by region, field office, and employee.

RRB did not maintain personnel activity reports or equivalent documentation nor did it use an approved substitute system to support the actual Medicare work performed as required by A-87. Personnel activity reports would include timesheets, logs, or in limited instances, time certifications. Circular A-87 also requires that support for salaries and wages reflect an after-the-fact distribution of the actual activity of each employee and account for the total activity for which each employee is compensated unless another substitute system has been approved by the cognizant federal agency (CMS in this case).

Finally, while required by A-87, RRB did not obtain signed certifications from those working solely on Medicare or from supervisory officials having direct knowledge of the work performed by the employee. For example, some Office of Programs employees' time was allocated 100 percent for reimbursement by CMS.

The RRB did not obtain adequate support for Medicare direct costs because they did not develop their cost allocation methodology in accordance with A-87. RRB management stated that a past workload committee decided to use employee profiles. These officials believed that management's professional judgment and preestablished employee profiles were the most cost effective and efficient means to track Medicare direct labor. BFO officials stated that in developing the agency's cost allocation plan, A-87 was only considered as guidance and the requirements were not adopted as agency requirements, as required by its interagency agreement with CMS. Further, RRB and CMS officials have supplemented, but not updated, their interagency agreement since 1991. OMB recommends that agencies review the terms and conditions annually for interagency agreements that exceed one year in length and execute amendments as necessary.¹⁴ BFO officials stated that CMS has not requested an update to the Medicare interagency agreement. As such, BFO's cost allocation methodology was not developed and certified in accordance with A-87 requirements.

Inaccurate and unsupported employee profiles can result in erroneous reimbursements by CMS for Medicare work performed by RRB. Unsupported direct labor costs totaling \$30.4 million were reported in the agency's cost allocation plans for the period from fiscal year 2010 through fiscal year 2014 because the RRB and CMS had not

¹⁴ The Department of Treasury also recommends governmentwide use of its interagency agreement form and provides instructions for reviewing the form annually.

established an OMB compliant direct labor cost system. In addition, indirect costs calculations are dependent on the accuracy of the total direct costs.

Recommendations

We recommend that the RRB Executive Committee:

1. perform a time study of Medicare work performed by all agency staff;
2. establish an A-87 compliant and CMS approved personnel activity report based system that will ensure the capture and reporting of actual Medicare work performed; and
3. update the RRB employee direct labor profiles to represent actual work performed based on an A-87 compliant system methodology.

We recommend that BFO:

4. adopt and implement A-87 as an agency requirement;
5. work with CMS to update the Medicare interagency agreement and establish procedures for maintaining and updating the agreement;
6. reevaluate the RRB's cost allocation plan and implement an A-87 compliant methodology for future Medicare direct labor costs using appropriate specialists and expertise;
7. utilize and maintain A-87 compliant personnel activity reports and employee certifications through authorization by the RRB's Executive Committee to ensure that reimbursed Medicare direct labor costs represent costs for actual and allowable Medicare work performed; and
8. work with CMS to determine, adjust, and correct any erroneous reimbursement of Medicare direct labor costs beginning with fiscal year 2010 to current based on actual work performed.

Management's Response & Our Comments

Recommendation 1: RRB management concurred with recommendation 1. While concurring, RRB management provided a modified solution to the recommendation. Management's response explained that a new personnel and payroll system is being implemented, which will have enhanced features that will allow the agency to code any agency personnel labor incurred from direct and indirect elements in order to track direct Medicare work performed. Further, RRB management indicated that at the time of transition to this system it will survey all agency personnel to determine what positions and personnel time is for direct labor for Medicare. We cannot conclude whether this

modified solution is viable as GSA is still in the vendor selection phase and the functionality of the new system has not been implemented or tested in the RRB work environment and is not expected to be functional until fiscal year 2018. However, RRB's current cost accounting system has the capability to accurately record Medicare work performed if it were properly configured. Implementation of a new payroll system was not necessary to implement this recommendation. RRB could complete an interim time study almost immediately to update the current employee's profiles. This action would better capture direct Medicare costs incurred by the RRB on behalf of CMS in compliance with A-87 until a new payroll system could be implemented.

Recommendations 2 and 3: RRB management did not concur with recommendations 2 or 3, which recommended actions the RRB could take to become compliant with its interagency agreement, for direct costs, which requires the implementation of A-87. In its response, RRB management stated that the RRB is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare. Finally, RRB identified the transition to a new payroll system as a step that will meet the portion of the recommendation addressing the capture and reporting of actual Medicare work performed.

The RRB's response is inaccurate and nonresponsive to these recommendations. First, as discussed in this report, we found that the cost allocation plan was not developed in compliance with A-87 for the determination of direct costs. Circular A-87 requires specific documentation and/or an approved system dependent upon if an employee is expected to work on a single cost objective or multiple cost objectives. For example, A-87 requires salaries to be supported by monthly signed personnel activity reports, a [CMS] approved statistical sampling system or other substitute system, and semi-annual employee signed certifications; none of which were completed by RRB. Instead, RRB relies on management's judgement to determine direct cost reimbursements from CMS. During the course of our work, RRB provided no evidence that its methodology for determining direct costs is in compliance with A-87. We requested documentation from RRB to support its statement in its written comments that it was in compliance with A-87 in determining direct costs. RRB replied that it did not have any additional documentation to provide. Second, the RRB's reference to a multiple allocation base method is nonresponsive as such terminology is applicable to the allocation of indirect costs, not direct costs, which are the focus of this finding and these recommendations. In order to be compliant with its interagency agreement, RRB must determine its direct costs using an A-87 compliant methodology. Finally, RRB's implementation of a new payroll system could improve the availability of A-87 compliant direct cost data on which to prepare its cost allocation plan if the system is properly configured and implemented. We cannot determine whether this modified solution is viable as GSA is still in the vendor selection phase and the functionality of the new system has not been implemented or tested in the RRB work environment and is not expected to be

functional until fiscal year 2018. However, RRB's current cost accounting system has the capability to accurately record Medicare work performed if it were properly configured.

Recommendation 4: In its response, RRB did not concur with this recommendation, which would require the adoption and implementation of A-87 as an agency requirement. In its response, RRB referred to its response to recommendation 2 where RRB stated it was in compliance with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare.

As detailed throughout this report, RRB does not comply with A-87 in the development of its cost allocation plan with CMS and its categorization of A-87 as guidance has not resulted in compliance with A-87, as required in its interagency agreement. Adoption and implementation of A-87 as an agency requirement would help to ensure compliance with the Circular and provide measures for assessing the accuracy of the \$100.5 million transferred to RRB from the Hospital Insurance and Supplementary Medical Insurance Trust Funds (Medicare Trust Funds) for fiscal years 2010 through 2014 and future reimbursements. Of the \$100.5 million, approximately \$31.5 million was SMAC costs. The RRB's statement that A-87 was used as a guide did not promote cost allocation plan accuracy and may allow for continued reimbursements by CMS based on a noncompliant system in future years.

Recommendation 5: RRB management concurred with recommendation 5, which recommended RRB work with CMS to update its interagency agreement and establish procedures for maintaining and updating this agreement. RRB management estimated the completion date to be September 29, 2017, which appears to coincide with the implementation of the new payroll system. While concurring, the RRB's estimated date of completion is not reasonable or proactive. The RRB could request an update to the interagency agreement immediately. Based on our discussion with CMS and as of June 28, 2016, RRB has not communicated with CMS about these findings. This completion date will delay the necessary updates to the interagency agreement and increase the risk of inaccurate Medicare reimbursements during fiscal years 2015, 2016, and 2017.

Recommendations 6 and 7: RRB did not concur with these recommendations, which included more specific steps the RRB should take to update its methodology to determine proper reimbursable direct costs including utilizing experts and collecting A-87 compliant direct cost data through personnel activity reports and employee certifications. RRB referred to its responses to recommendations 1 and 2 in providing its comments on these recommendations. In those responses, RRB explained that a new payroll system is being implemented, which will have enhanced features that will allow the agency to code any agency personnel labor incurred from direct and indirect elements in order to track direct Medicare work performed. Further, RRB management

indicated that at the time of transition to this system, it will survey all agency personnel to determine what positions and personnel time is for direct labor for Medicare. RRB stated that it is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare. We requested documentation from RRB to support its statement in its written comments that it uses a multiple allocation base method for indirect costs. RRB replied that it did not have any additional documentation to provide.

RRB's implementation of a new payroll system could improve the availability of A-87 compliant direct cost data on which to prepare its cost allocation plan if the system is properly configured and implemented, which would support implementation of recommendation 6. However, we cannot determine whether this modified solution is viable as GSA is still in the vendor selection phase and the functionality of the new system has not been implemented or tested in the RRB work environment and is not expected to be functional until fiscal year 2018. However, by nonconcurring with this recommendation, the RRB is instead continuing to rely on a noncompliant in-house cost allocation process rather than engage experts to establish a compliant methodology for determining direct costs for reimbursement by CMS.

The remaining comments by RRB are nonresponsive to the recommendations and disregard the numerous instances of noncompliance we found in RRB's determination of direct costs. As we have stated previously, A-87 requires personnel activity reports and employee certifications; none of which were completed by RRB. RRB relies on management's judgement to determine direct cost reimbursements from CMS. During the course of our work and in its comments, RRB provided no evidence that its methodology for determining direct costs is in compliance with A-87. Second, the RRB's reference to a multiple allocation base method is nonresponsive as such terminology is applicable to the allocation of indirect costs, not direct costs, which are the focus of this finding and these recommendations. In order to be compliant with its interagency agreement, RRB must determine its direct costs using an A-87 compliant methodology, as described in these recommendations.

Recommendation 8: RRB did not concur with this recommendation, which called for the agency to work with CMS to determine, adjust, and correct any erroneous reimbursements by CMS related to direct labor costs from fiscal year 2010 to current. In its response, RRB management stated that although the draft report informed the agency of potential reimbursement under or overstatements and asserted that the agency is not following regulatory requirements and not establishing a cost allocation methodology that its response to recommendation 2 clarifies the agency's compliance. RRB went on to state that the audit report does not provide explicit reference to actual reconciled data supporting estimates and projections and that the analysis used to make projections was not supported by statistically valid sampling methods.

RRB management's response to our recommendation is concerning and indicates an unwillingness to resolve potentially significant erroneous reimbursements of direct costs by the Medicare Trust Funds. As it relates to direct cost reimbursements, our work found that the RRB requested and received approximately \$30.4 million in unsupported direct labor costs from CMS for fiscal years 2010 through 2014. These unsupported reimbursements were the result of the RRB's noncompliance with A-87's requirements to maintain personnel activity reports for staff working on Medicare and other RRB programs and obtain signed certifications from those working solely on Medicare. Instead, RRB used preestablished employee profiles to estimate these direct costs, which are supported only by management's professional judgement and not by quantifiable or captured data. RRB has provided no further evidence or information that its methodology for determining direct labor costs is in compliance with A-87. We requested documentation from RRB to support its statement in its written comments that it was in compliance with A-87 in determining direct costs. RRB replied that it did not have any additional documentation to provide. In its response, RRB stated that our audit did not provide explicit reference to actual reconciled data supporting estimates or projections and that the analysis used to make projections was not supported by statistically valid sampling methods. It appears this response does not relate to recommendation 8, which addresses direct costs and makes no estimates or projections. We did not make any estimates or projections related to direct costs because any estimate we could have made, based on our audit methodology and information available to us, would not have been in compliance with A-87. Further, such estimates or projections would require information that RRB management would best be in the position to obtain. We did note instances where our work indicated that the underlying direct cost profiles may have been incorrect based on in-depth in person interviews with RRB staff throughout the country and suggest that RRB may be under reimbursed for certain direct costs. The materiality of the potential under and over reimbursements warrant management's attention.

Medicare Indirect Costs Were Not Properly Allocated

RRB's methodology for allocating its Medicare indirect costs for reimbursement was not in accordance with A-87 requirements.¹⁵ The cost allocation plan methodology did not provide an equitable or consistent distribution of Medicare indirect costs. Indirect costs were reported in the agency's cost allocation plans and totaled approximately \$36.1 million for fiscal years 2010 through 2014. Using A-87 prescribed methods, we estimate that reimbursements to RRB exceeded allowable amounts ranging from \$9.5 million to \$33.8 million for fiscal years 2010 through 2014.

¹⁵ BFO allocates costs to the Medicare and Railroad Retirement programs in Schedule F of the agency's cost allocation plan. Schedule F represents the summary of costs allocated to the Medicare Program, including both labor and non-labor costs.

An Indirect Cost Rate Had Not Been Established and Approved

The RRB had not established a predetermined and CMS approved Medicare indirect cost rate. Further, the RRB allocates all agency costs, except for Medicare direct labor and Medicare contracts, as a ratio of Medicare and other Railroad Retirement programs. The RRB's cost allocation methodology and logic was not adequately described in its cost allocation plan.

Circular A-87 explains that when an agency's major functions benefit from its indirect costs to approximately the same degree, the allocation of indirect costs and the computation of an indirect cost rate may be accomplished through simplified allocation procedures. This allocation may be accomplished by classifying the agency's total costs for the base period as either direct or indirect and dividing the total allowable indirect costs by an equitable distribution base, as shown in the following equation:

$$\text{Indirect cost rate} = \text{Total allowable indirect costs} / \text{equitable distribution base}$$

The equitable distribution base may be (1) total direct costs excluding capital expenditures and other distorting items, (2) direct salaries and wages, or (3) another base which results in an equitable distribution. The indirect cost rate is multiplied by the distribution base total to calculate reimbursable indirect costs. Alternately, A-87 states that a standard indirect cost rate equal to 10 percent of the direct salary and wage cost of providing the service may be used in lieu of determining the actual indirect costs of the service, as described above.

The RRB's indirect cost methodology is not in accordance with A-87 because total indirect costs were not approved by CMS and were not allocated using a predetermined indirect cost rate based on historical cost data and utilizing an agreed upon, equitable distribution base. We calculated the RRB's average Medicare indirect cost rate for the five year period of review to be 119 percent.¹⁶

For fiscal years 2010 through 2014, we compared RRB's methodology for determining indirect costs with two compliant alternatives provided in A-87. Actual questioned costs will depend on the actions taken by RRB officials and CMS approval.

¹⁶ RRB does not calculate the indirect cost rate in its cost allocation plan. Therefore, we calculated the rate by dividing the RRB's costs claimed per Schedule F in the cost allocation plan by Medicare direct labor costs from the RRB's cost accounting system. For fiscal years 2010-2014, the calculated rates were 116, 118, 112, 119, and 128 percent, respectively, for an average rate of 119 percent.

We summarized the comparison of the two indirect cost rate alternatives in Table 5.

Table 5: Questioned Medicare Indirect Costs Fiscal Years 2010 – 2014 (dollar amounts in millions)				
Indirect Cost Method Alternative	Indirect Cost Rate	Indirect Cost Allowed	RRB's Indirect Costs Claimed	Questioned Costs
OMB Standard Rate	10.0%	\$2.3	\$36.1	\$33.8
OMB Simplified Method	32.2% - 96.5%	\$11.3 - \$26.6	\$36.1	\$9.5 - \$24.8
Key Assumptions: OMB Standard Rate: All of RRB's reported Medicare direct labor costs are accurate and allowable and a uniform indirect cost rate of 10 percent is applied. OMB Simplified Method: All of RRB's reported Medicare direct labor costs are accurate and allowable. However, because agency indirect labor costs were not approved by CMS, they are potentially unallowable. This uncertainly results in a range of questioned costs.				

We provided details of our comparison of the two indirect cost rate alternatives for each fiscal year in Tables 6 and 7. As shown in Table 6, OMB's standard indirect cost rate of 10 percent results in overallocated indirect costs totaling \$33.8 million for the period.

Table 6: OMB Standard Indirect Cost Rate - 10 Percent (dollar amounts in millions)					
	[A]	[B]	[C] = [A] x [B]	[D]	[E] = [D] - [C]
Fiscal Year	RRB's Medicare Direct Labor Costs (Net) ⁱ	Standard Indirect Cost Rate ⁱⁱ	Allowable Indirect Costs per Standard Indirect Cost Rate	RRB's Actual Indirect Costs Claimed ⁱⁱⁱ	Overallocated Indirect Costs
2010	\$4.3	10%	\$0.4	\$6.5	\$6.1
2011	4.7	10%	0.5	7.3	6.9
2012	4.8	10%	0.5	7.1	6.6
2013	4.5	10%	0.4	7.0	6.5
2014	4.9	10%	0.5	8.2	7.7
Total	\$23.2	--	\$2.3	\$36.1	\$33.8
Note: numbers in this table may not add up due to rounding.					
ⁱ Medicare direct labor costs net of overtime and benefits from RRB's cost accounting system based on employee profiles.					
ⁱⁱ All of RRB's reported Medicare direct labor costs are assumed accurate and allowable and a uniform indirect cost rate of 10 percent is applied.					
ⁱⁱⁱ Amounts per the RRB's Cost Allocation Plans.					

As shown in Table 7, OMB's simplified method results in a range of potentially overallocated indirect costs totaling between \$9.5 and \$24.8 million for the period with final determination pending CMS review and approval.

Table 7: OMB's Simplified Method (dollar amounts in millions)					
Fiscal Year	[A] RRB's Medicare Direct Labor Costs ⁱ	[B] Indirect Cost Rate per Simplified Method ⁱⁱ	[C] = [A] x [B] Allowable Indirect Costs per Simplified Method	[D] RRB's Actual Indirect Costs Claimed ⁱⁱⁱ	[E] = [D] - [C] Overallocated Indirect Costs
2010	\$5.6	34.1% - 84.4%	\$1.9 - 4.7	\$6.5	\$1.8 - 4.6
2011	6.2	32.2% - 82.6%	2.0 - 5.1	7.3	2.2 - 5.3
2012	6.3	35.4% - 85.8%	2.2 - 5.4	7.1	1.6 - 4.8
2013	5.9	37.5% - 87.9%	2.2 - 5.2	7.0	1.8 - 4.8
2014	6.4	46.1% - 96.5%	3.0 - 6.2	8.2	2.0 - 5.3
Total	\$30.4	--	\$11.3 - 26.6	\$36.1	\$9.5 - 24.8

Note: numbers in this table may not add up due to rounding.

ⁱ Medicare direct labor costs from RRB's cost accounting system including salaries and benefits of RRB's employees based on employee profiles.

ⁱⁱ All of RRB's reported Medicare direct labor costs are assumed accurate and allowable. However, because agency indirect labor costs were not approved by CMS, they are potentially unallowable. This resulted in a range of percentages, allowable indirect costs, and questioned costs shown above.

ⁱⁱⁱ Amounts per the RRB's Cost Allocation Plans.

These issues and potential over allocation of indirect costs occurred because BFO's indirect cost allocation methodology was not developed, certified by the RRB, and approved by the CMS in accordance with A-87 requirements. BFO's methodology for allocating Medicare indirect costs resulted in potential over reimbursement by CMS for Medicare work performed by the RRB. As shown in Table 5, the total amount could result in questioned costs of up to \$33.8 million dollars for the five year period. Consequently, because control weaknesses were identified and Medicare funding was potentially over allocated, there is a heightened risk of an Antideficiency Act violation.

Recommendations

We recommend that BFO:

9. develop and certify an indirect cost methodology and rate that complies with A-87 using appropriate specialists and expertise;
10. obtain CMS approval for the indirect cost methodology and rate developed based on the recommendations in this report;

11. determine the correct Medicare indirect cost reimbursement amount for fiscal years 2010 to current using the compliant indirect cost rate for the period; and
12. establish procedures requiring annual certification of the cost allocation plan and indirect cost rate prior to reimbursement that complies with A-87.

Management's Response & Our Comments

Recommendation 9: RRB management did not concur with this recommendation, which recommended utilizing a specialist or experts to develop and certify an indirect cost methodology and rate that complies with A-87. In its response, RRB management referred to its response to recommendation 2, which stated that it is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, RRB indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare. The response to recommendation 2 also refers to the implementation of a new payroll system, which they state will capture and report actual Medicare work performed.

Fundamentally, RRB and RRB OIG disagree on the applicability of and the RRB's compliance with A-87. In its written comments, RRB states it is in compliance with A-87, by using a multiple allocation base method. By OMB's definition, the multiple allocation base method is used when an agency's indirect costs benefit its major functions in varying degrees. RRB did not provide justification or explain why this method was more appropriate for the agency than the simplified method. There are elements of RRB's cost allocation method that somewhat resemble the multiple allocation base method, for example, the use of retirement and unemployment program cost groupings and ratios. However, there are notable differences including the absence of a consistent cost grouping for Medicare. In addition, we noted the RRB's use of Office of Programs and Field Service cost groupings with the absence of a Bureau of Information Systems cost grouping. The RRB did not define the proportional benefit for each functional cost grouping or distinguish the operating differences that result in material differences in the use of resources and costs. The RRB also used ratios rather than selecting an appropriate base for distribution of each cost grouping that would produce an equitable result. The RRB also failed to establish a CMS preapproved and A-87 compliant indirect cost rate for each specific cost grouping.

Further, during the course of our audit, RRB never presented documentation that indicated its use of this methodology and first recognized the method in its management's response to our draft report. We requested documentation from RRB to support its statement in its written comments that it uses a multiple allocation base method for indirect costs. RRB replied that it did not have any additional documentation to provide. Because of the differences between what A-87 defines as the multiple

allocation base method and how RRB is allocating indirect costs, we do not believe the indirect cost allocation is in compliance with A-87. Because of the differences in allocation methodologies allowed in A-87, our report presents a range of indirect cost rates that would have met the requirements of A-87. Using its current methodology, RRB's average indirect cost rate for the period of review was 119 percent, a rate that indicates the RRB's indirect costs exceed direct costs and significantly exceeds OMB's standard rate of 10 percent.

Recommendation 10: RRB management did not concur with this recommendation, which recommended RRB obtain CMS approval of its indirect cost methodology and rate developed based on the recommendations in this report. In its response, RRB management referred to its response to recommendation 2, which stated that it is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare. Finally, RRB states that for each year included in the audit report, it received CMS's signed acceptance and approval of the cost allocation plan.

As discussed in recommendation 9, RRB's assertion that it uses a multiple allocation base method to allocate indirect costs is inaccurate because its allocation methodology does not meet key requirements of the multiple allocation base method in A-87. Further, while CMS has signed the cost allocation plan annually, RRB does not present an indirect cost rate thus, CMS has not approved such a rate, as required by A-87. Conducting an audit of CMS is outside the scope of our authority; however, because of the significance of our findings and the potential impact to CMS, we briefed CMS on our preliminary findings in June 2016. CMS officials expressed concern about the impact to the Medicare Trust Funds and stated that the RRB's cost allocation plan had not been clearly understood by CMS officials. These officials explained that CMS does not currently have the resources to closely review the underlying costs and allocation methodology and it relies on the RRB to provide accurate and compliant cost support for the agency's Medicare reimbursements. Because of the multiagency impact of its cost allocation plan, RRB officials have an even greater responsibility to assure the accuracy of its cost allocation plan and should take all necessary steps to implement not only this recommendation, but all others throughout this report.

Recommendation 11: RRB management did not concur with this recommendation, which recommended RRB determine the correct Medicare indirect cost reimbursement amount for fiscal years 2010 to current using the compliant indirect cost rate for the period. In its response, RRB management referred to its response to recommendation 2, which stated that it is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they

indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare. RRB management also referred to its response to recommendation 8, which indicated that although the draft report informed the agency of potential over or under reimbursement and asserted that the agency is not following regulatory requirements that it is in fact in compliance with A-87. The response goes on to state that the audit report does not provide explicit reference to actual reconciled data supporting estimates and projections and that the analysis used to make projections was not supported by statistically valid sampling methods. Finally, in its response, RRB management indicated that it will continue to strengthen its validation processes by including statistical valid sampling of profiles until the implementation of its new payroll system, which will provide direct tracing for Medicare costs.

As discussed in recommendation 9, RRB's assertion that it uses a multiple allocation base method to allocate indirect costs is inaccurate because its allocation methodology does not meet key requirements of the multiple allocation base method in A-87. For example, the RRB did not define the proportional benefit for each functional cost grouping nor distinguish the operating differences that result in material differences in the use of resources and costs. Additionally, the RRB failed to establish a CMS preapproved and A-87 compliant indirect cost rate for each specific cost grouping.

Regarding RRB's response that our audit did not provide explicit reference to actual reconciled data supporting estimates or projections and that the analysis used to make projections was not supported by statistically valid sampling methods. Our audit report states that we compared RRB's noncompliant methodology for determining indirect costs with two A-87 compliant methodologies and that actual questioned costs would depend on actions taken by RRB officials and CMS approval. The intent of providing these alternatives was to demonstrate the potentially significant differences between RRB's methodology, which currently results in an indirect cost rate of 119 percent, and A-87 compliant methodologies. Our comparison demonstrated a range of indirect cost rates from 10 percent, using the OMB's standard rate, to 96.5 percent, using the OMB's simplified method. Throughout the course of our audit, we met with RRB officials to discuss our analysis and provided them documentation of such analysis. Based on information provided by RRB, we refined our analysis. Based on this analysis and the totality of our work, we presented a range of estimates to demonstrate the importance of developing and implementing an A-87 compliant allocation methodology, which is the purpose of this recommendation.

Finally, RRB's response included steps it will take to address direct costs for Medicare reimbursement including strengthening its validation process by including statistical sampling of profiles until its new payroll system is implemented. This change will largely affect direct costs, which are a component of indirect cost calculations. Steps taken to improve the quality of cost data should help improve cost allocation plan accuracy if done in accordance with A-87. We do note that this proposal implies concurrence with recommendations 3, 6, 7, and 8, which RRB management did not concur with in its responses.

Until the RRB develops an A-87 compliant cost allocation base and methodology, it may continue to receive significant, erroneous reimbursements of indirect costs from the Medicare Trust Funds. Currently, RRB receives approximately \$7.2 million annually from CMS for the reimbursement of its indirect Medicare costs.

Recommendation 12: RRB management did not concur with this recommendation, which call for RRB to establish procedures requiring annual certification of the cost allocation plan and indirect cost rate prior to reimbursement that complies with A-87. In its response, RRB management referred to its response to recommendation 2, which stated that it is compliant with A-87 and uses a multiple allocation base method for costs. RRB also stated that although the annual cost allocation plan does not explicitly state the methodology, the document explicitly states that A-87 was used as a guide to develop the cost allocation plan. Further, they indicated that the multiple allocation base method is explicitly displayed in supporting schedules and exhibits, which identify procedures used to develop cost reimbursement for Medicare.

RRB's management response is nonresponsive to recommendation 12 and reiterated their previous belief that the agency is compliant. We continue to recommend that the RRB establish A-87 compliant procedures requiring annual certification of the cost allocation plan and indirect cost rate prior to reimbursement.

Unexplained Indirect Cost Variances Were Identified

Indirect costs did not change in reasonable proportion with direct labor costs during fiscal years 2011 through 2014. The two unexplained variances described below were based on historical agency costs. We conducted a year-to-year trend analysis of key departments and line items and determined that Medicare costs both direct and indirect increased considerably from fiscal year 2010 to fiscal year 2011 and again from fiscal year 2013 to fiscal year 2014 for Office of Programs Field Service. After further analysis of applicable salaries and benefits, including interviews with Office of Programs staff, we determined the direct cost increases were reasonable because of the cyclical hiring of new Medicare claims examiners. However, we determined the indirect costs increased unreasonably by comparing and analyzing year-to-year costs presented for each year.

In fiscal year 2011, Medicare direct labor costs for the Office of Programs and Field Service increased by \$584,453 (16 percent growth) from the prior fiscal year. Whereas, their Medicare indirect costs increased by \$861,010 resulting in an indirect cost rate of 147 percent.¹⁷ However in fiscal year 2014, Medicare direct labor costs for the same two direct labor components increased by \$436,476 (11 percent growth) from the prior fiscal year. Whereas, their Medicare indirect costs increased by \$1,247,256, resulting in an indirect cost rate of 286 percent.

The unexplained indirect cost variances resulted from noncompliance with A-87 and

¹⁷ We calculated the rate by dividing indirect costs by direct costs per Schedule F costs.

were not identified because a variance analysis control process had not been established. The effectiveness of RRB's Medicare cost allocation policies, procedures, and quality control mechanisms are discussed later in this report. As such, BFO did not identify the variances that could have identified the methodology weaknesses and over reimbursements discussed in this report.

Recommendation

We recommend that BFO:

13. establish a variance analysis control process that will help to identify indirect cost reimbursement miscalculations and ensure timely corrective action.

Management's Response & Our Comments

Recommendation 13: RRB management did not concur with this recommendation, which recommended the establishment of a variance analysis control process to help identify indirect or direct cost reimbursement miscalculations and ensure timely corrective action. RRB's management stated that the methodology used in the audit report is not evident and that percentage change calculations compare changes year-to-year, which discount the impact of cost pool changes (the base for determining direct and indirect percentages) within the year. We provided and discussed the methodology for identifying the variances with RRB officials on multiple occasions throughout the audit. Based on RRB's response, we expanded the description of our trend analysis in this section of the report. The variances considered and applied the impact of reciprocal changes in direct and indirect costs. The RRB cost allocation plan does not utilize A-87 compliant proportional benefitting indirect cost pools for cost allocation purposes and the impact of such changes would not apply. We continue to recommend the establishment of a variance analysis control process to identify indirect or direct cost reimbursement miscalculations particularly during the five year period reviewed as this audit indicated that indirect costs did not change in reasonable proportion to direct labor costs during fiscal years 2011 through 2014, as detailed earlier in this report.

Allocated Indirect Agency Labor and Non-Labor Costs Were Not Approved

Historically, the RRB has allocated all of the agency's indirect labor and non-labor costs for Medicare reimbursement. These allocated costs included 91 indirect labor codes that were not directly traceable to the Medicare program and were not reviewed for allowability and preapproved by CMS, as required by A-87. The indirect labor costs represented more than \$19.2 million in reimbursements for fiscal years 2010 through 2014.

The allocated costs also included indirect non-labor costs that were not adequately disclosed and reviewed by CMS for allowability prior to reimbursement. These costs totaled approximately \$16.9 million for the same period.

These issues occurred because BFO's indirect cost allocation methodology was not developed, certified by the RRB, and approved by CMS in accordance with A-87 requirements. Also, the RRB's Medicare cost allocation plan had not been certified by the agency's Chief Financial Officer prior to submission for cost reimbursement as required by A-87.

This condition is a contributing factor to RRB's potential over allocation of indirect costs as previously discussed.

Recommendations

We recommend that BFO:

14. submit a detailed indirect cost rate proposal in support of its allowable and allocable indirect labor costs to CMS for approval prior to reimbursement; and
15. work with CMS to determine, adjust, and correct any erroneous reimbursements resulting from the allocation of all of the RRB's indirect labor and non-labor costs beginning with fiscal year 2010 to current.

Management's Response & Our Comments

Recommendation 14: RRB management did not concur with this recommendation, which was aimed at assuring it was in compliance with the A-87 requirement that the indirect cost rate proposal be reviewed for allowability and approved by CMS before the RRB submits the cost allocation plan.

In its nonconurrence, RRB referred to its response to recommendation 10 that stated RRB has received CMS's signed acceptance and approval of the cost allocation plan for each year examined in this audit. While CMS has signed the cost allocation plan annually, RRB does not present an indirect cost rate. As such, CMS has not approved such a rate, as required by A-87. We calculated an average indirect cost rate of 119 percent. Conducting an audit of CMS is outside of our authority; however, because of the significance of our findings and the potential impact to CMS, we briefed CMS on our preliminary findings in June 2016. CMS officials expressed concern about the impact to the Medicare Trust Funds and stated that the cost allocation plan had not been clearly understood by CMS officials. These officials explained that CMS does not currently have the resources to closely review the underlying costs and allocation methodology and it relies on the RRB to provide accurate and compliant cost support for the agency's Medicare reimbursements. Because of the multiagency impact of its cost allocation plan and the \$7.2 million annually reimbursed for indirect costs, RRB should take all necessary steps to implement this recommendation. Finally, by reference in recommendation 10, RRB referred to its response to recommendation 2, although it is unclear if RRB intended for this response to be applicable to this recommendation. Our discussion of recommendation 2 can be found earlier in this report.

Recommendation 15: RRB management did not concur with this recommendation, which called for the agency to work with CMS to determine, adjust, and correct any erroneous reimbursements resulting from the allocation of all of the RRB's indirect labor and non-labor costs beginning with fiscal year 2010 to current. In its response, RRB management stated that although the draft report informed the agency of potential reimbursement under or overstatements and asserted that the agency is not following regulatory requirements and not establishing a cost allocation methodology its response to recommendation 2 clarifies the agency's compliance. RRB went on to state that the audit report does not provide explicit reference to actual reconciled data supporting estimates and projections and that the analysis used to make projections was not supported by statistically valid sampling methods.

As stated in this report, RRB has not submitted a detailed indirect cost rate proposal to CMS for approval prior to reimbursement as required by A-87. Indirect labor and non-labor costs for the years reviewed in this audit, and the subject of this recommendation, are \$19.2 million and \$16.9 million, respectively. Because CMS has not yet reviewed and approved the indirect cost allocation methodology, in conjunction with the other weaknesses identified in this report, there are potentially erroneous reimbursements of indirect costs by the Medicare Trust Funds that necessitate a retroactive review and correction, if necessary.

RRB Has a Heightened Risk of an Antideficiency Act Violation

Because the RRB did not comply with A-87 it may have received reimbursements, particularly for indirect costs, that exceeded allowable amounts. As a result, the RRB may have received funds ranging from \$9.5 million to \$33.8 million more than allowable for fiscal years 2010 through 2014.

Depending on the final determination of the correct reimbursement for the five year period, the RRB may have violated the Purpose Statute and/or the Antideficiency Act. Table 8 shows the potential shortfall or surplus in each annual appropriation based on the range of estimates we calculated for reimbursements that exceeded allowable amounts in compliance with A-87.

Table 8: Excessive Reimbursements and Potential Appropriation Shortage
(dollar amounts in millions)

Fiscal Year	Reimbursement Exceeding Allowable Costs as Identified in this Audit		Unobligated Balance ¹	Potential Shortage/Surplus in Appropriation	
	Lower Range from Table 7	Upper Range from Table 6		Lower Range	Upper Range
2010	\$1.8	\$6.1	\$0	\$1.8	\$6.1
2011	2.2	6.9	1.0	1.2	5.9
2012	1.6	6.6	0.2	1.4	6.4
2013	1.8	6.5	0.4	1.4	6.1
2014	2.0	7.7	3.0	\$1.0 Surplus	4.7
2015 ^{II}	--	--	0.9	--	--
2016 ^{II}	--	--	20.5	--	--
No Year Funds	--	--	\$3.1	\$3.1 Surplus	\$3.1 Surplus
Total	\$9.5	\$33.8	\$29.0	\$1.7	\$26.2

Note: numbers in this table may not add up due to rounding.

¹ Source: RRB's Governmentwide Treasury Account Symbol Adjusted Trial Balance System (GTAS) Cross Walk to SF 133, 1st quarter fiscal year 2016, dated 1/21/2016

^{II} At the time of this audit, we could not obtain the actual 2015 or 2016 reimbursement amounts because the RRB has yet to publish its respective cost allocation plans.

If the RRB's Medicare reimbursement was used for another purpose than allowed through appropriations, a violation of 31 USC Section 1301(a), commonly known as the Purpose Statute may have occurred.¹⁸ If the RRB is not able to resolve the Purpose Statute violation, it results in a violation of the Antideficiency Act.

Violations of the Purpose Statute can be resolved by deobligating those amounts charged to the wrong appropriation and obligating the amounts to an appropriation available for that purpose. However, as shown in Table 8, the appropriation funding may no longer be available. As of January 21, 2016, RRB had approximately \$4.6 million available in unobligated funds for this five year period in the appropriation account.

Further, 31 USC Section 1341(a) prohibits officers and employees of the federal government from making or authorizing an expenditure or obligation that exceeds an amount available in an appropriation or fund for the expenditure or obligation.¹⁹ If RRB received reimbursements from CMS in excess of those allowed under A-87 and its interagency agreement with CMS, it should return the excess funds to CMS. If sufficient funds are not available to return the over reimbursed funds, RRB is required to report this as a violation of the Antideficiency Act.

¹⁸ Public Law 97-258, September 13, 1982.

¹⁹ Public Law 97-258, September 13, 1982 as amended by Public Law 101-508, November 5, 1990.

Recommendation

We recommend that the RRB Executive Committee:

16. conduct a thorough investigation and determine if the Purpose Statute and/or Antideficiency Act was violated as a result of the RRB's Medicare reimbursement process and report violations in accordance with OMB Circular A-11.

Management's Response & Our Comments

Recommendation 16: RRB management did not concur with this recommendation that, based on the totality of the findings in this audit, called for RRB management to conduct a thorough investigation to determine if there were violations of the Purpose Statute and/or the Antideficiency Act and report any identified violations in accordance with OMB Circular A-11. In its response, RRB management referred to its responses to recommendations 2 and 8, which stated that the RRB is compliant with A-87 and uses a multiple allocation base method for costs. The responses also stated the transition to a new personnel and payroll system will capture and report actual Medicare work performed. RRB's response stated that although the draft report informed the agency of potential reimbursement under or overstatements and asserted that the agency is not following regulatory requirements and not establishing a cost allocation methodology as prescribed, its response clarifies the agency's compliance. The response also stated that the audit report does not provide explicit reference to actual reconciled data supporting estimates and projections over the period audited from 2010 through 2014. Additionally, the analysis used to make projections was not supported by statistically valid sampling methods.

As shown in this report, we found that the cost allocation plan was not developed in compliance with A-87 and as a result RRB may have received reimbursements, particularly for indirect costs, that exceeded allowable amounts. For direct costs, A-87 requires specific documentation and/or an approved system dependent upon if an employee is expected to work on a single cost objective or multiple cost objectives. For example, A-87 requires salaries to be supported by monthly signed personnel activity reports, a [CMS] approved statistical sampling system or other substitute system, and semi-annual employee signed certifications; none of which were completed by RRB. RRB relies on management's judgement to determine direct cost reimbursements from CMS. Further, RRB states that it uses a multiple allocation base method, which is an A-87 methodology for allocating indirect costs.

The multiple allocation base method is used when an agency's indirect costs benefit its major functions in varying degrees. RRB did not provide justification or explain why this method was more appropriate for the agency than the simplified method. As discussed in recommendation 9, there are elements of RRB's indirect cost allocation that are similar to the multiple allocation base method, for example, the use of program cost groupings. However, there are notable differences including the absence of a consistent

cost grouping for Medicare and the absence of a Bureau of Information Systems cost grouping. Further, the RRB did not define the proportional benefit for each functional cost grouping or distinguish the operating differences that result in material differences in the use of resources and costs. The RRB also used ratios rather than selecting an appropriate base for distribution of each cost grouping that would produce an equitable result. The RRB also failed to establish a CMS preapproved and A-87 compliant indirect cost rate for each specific cost grouping.

During the course of our audit, RRB never provided documentation supporting their use of the multiple allocation base method and first identified the method in its written management's response to our draft report. We requested documentation from RRB to support its statement in its written comments that it uses a multiple allocation base method for indirect costs. RRB replied that it did not have any additional documentation to provide. Because of the differences between what A-87 defines as the multiple allocation base method and how RRB is allocating indirect costs, we do not believe its indirect cost allocation is in compliance with A-87. Because of the differences in allocation methodologies allowed in A-87, our report presents a range of indirect cost rates that would have met the requirements of A-87 for comparison purposes. These estimates utilized RRB cost data and provided a range of estimated overpayments that are dependent on CMS approval of costs. We believe that our analysis provides a reasonable basis for estimating a range of potential outcomes of the RRB's noncompliance with A-87. Our range of estimates also reflect CMS' ability to reject submitted Medicare costs as they had not been subject to review and approval. The cost allocation plan had been approved by CMS without submission of a RRB certified indirect cost rate proposal. We continue to recommend that the RRB investigate and determine if the Purpose Statute and/or Antideficiency Act was violated and, if identified, report violations in accordance with OMB Circular A-11.

RRB's Medicare Cost Allocation Policies, Procedures, and Quality Control Mechanisms Were Not Effective

Our audit also discovered deficiencies regarding RRB policies and procedures over its Medicare cost allocation activities. Procedures did not explain how costs included in the cost allocation plans would be determined and cost components calculated; and they did not address quality control over the preparation of the plans.

Cost Allocation Plan Procedures Have Not Been Fully Developed

BFO's procedures for developing the RRB's cost allocation plan have not been fully developed and are not effective. BFO's procedures do not:

- address development and approval of an indirect cost rate;
- provide instructions for complying with A-87's cost allocation plan certification requirements; or

- include supportive rationale for how the agency's direct and indirect costs are to be computed.

The RRB's Chief Financial Officer is required to certify the plan annually prior to submission to CMS for Medicare cost reimbursement. Prior to issuance of the fiscal year 2014 and 2015 cost allocation plan, we informed BFO of A-87's requirements, however, the RRB subsequently released the cost allocation plan without proper certification.

BFO included two of the eight components that charged direct Medicare labor in its indirect cost allocation methodology. However, total direct labor costs for all components reporting direct Medicare activity are needed as an equitable distribution base to ensure proper allocation of indirect costs. Further, there was no indication that the Chief Financial Officer obtained necessary approvals from the RRB's Board members for allocating reimbursable funding to appropriate RRB activities, as required by RRB's internal policy.

In addition, the procedures lacked staffing contingency and succession planning to ensure consistent and timely preparation of the plan. During our audit, we observed the effect of this lack of planning as recent turnover resulted in a responsibility shift where the RRB had not adequately trained assigned staff in cost allocation plan preparation and compliance. Since April 2010, five different RRB employees have certified the cost allocation plan.

In implementing the Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book), management is responsible for designing the policies and procedures to fit an entity's circumstances and building them in as an integral part of the entity's operations.²⁰ Further, management should define succession plans for key roles and train succession candidates to assume the key roles. Management should define contingency plans for assigning responsibilities if a key role in the entity is vacated without advance notice.

BFO officials stated they only use A-87 as guidance in developing the cost allocation plan and do not believe they need to comply with its requirements. There is no indication the RRB's Board members reviewed or approved the plans as required by RRB procedures. There was no indication that BFO officials had received training on the requirements of interagency agreements or A-87.

If cost allocation plan procedures are not developed to ensure compliance with A-87, Medicare program costs may not be allocated and reimbursed appropriately in future years. Without a trained and experienced cost accountant, plan preparation and reimbursement from CMS for Medicare related expenses may be delayed or inaccurate.

²⁰ Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G (Washington, D.C.: September 10, 2014).

Recommendations

We recommend that BFO:

17. revise their cost allocation plan procedures to include: (1) an explanation and rationale for its plan methodology; (2) the development of an indirect cost rate; (3) certification requirements and instructions; and (4) succession and contingency planning for the role of preparing the plan;
18. conduct training to ensure the cost allocation plan is reviewed and approved by the RRB's Board members as required; and
19. obtain all necessary training on the requirements of federal interagency agreements and A-87 in order to properly prepare and submit its Medicare cost allocation plan.

Management's Response & Our Comments

Recommendations 17, 18, and 19: RRB management concurred with these recommendations. Management's estimated completion date is April 28, 2017.

Cost Allocation Plan Quality Control Is Not Effective

The RRB's quality control over the preparation and completion of the cost allocation plan is ineffective. During our audit, we found several noncompliance issues, calculation errors, and reporting inconsistencies in the fiscal year 2013 and 2014 plans that could have been prevented with adequate quality control practices. For example, the RRB's cost allocation plans were not certified by the Chief Financial Officer or issued timely. The plans contained rounding errors in the Part A calculations; and mathematical, data entry, and classification errors impacted the Part B cost presentation. In addition, BFO did not always clearly define or explain cost elements of the plans.

According to Government Accountability Office's Green Book, management should establish and operate monitoring activities to monitor the internal control system and evaluate the results.

Cost allocation plan quality control mechanisms have not been established and are not addressed in the RRB's procedures.

While the identified errors and inconsistencies were not material, cost allocation plan inaccuracies can potentially result in monetary errors impacting the millions of dollars of Medicare cost reimbursements and these errors are unlikely to be detected by BFO's current procedures.

Recommendation

We recommend that BFO:

20. establish and implement quality control mechanisms to ensure the accuracy of the cost allocation plan reporting and reimbursed Medicare costs.

Management's Response & Our Comments

Recommendation 20: RRB management concurred with this recommendation. The estimated completion date is April 28, 2017.

Additional Concerns With RRB's Cost Allocation Plan

In the course of our work, we noted that certain RRB management costs were not recorded uniformly, as required by A-87, and that cost accounting profiles for former employees were still maintained in the cost accounting system.

Medicare Management Costs Were Not Recorded Uniformly

The RRB did not record Medicare management costs consistently across the agency. BFO established a profile code for Medicare management direct labor costs in the agency's cost accounting system. However, our review identified six managers from BFO, Bureau of Information Services, Field Service, and Office of Administration who had presumed Medicare responsibilities that were not assigned the Medicare management code in their employee profiles. Each of these managers supervised staff that worked on Medicare. Their Medicare assignments would presumably be subject to review by the responsible manager.

In addition, Office of Programs and Field Services direct management costs were erroneously included by BFO as indirect costs although a profile code had been established for Medicare management costs in the agency's cost accounting system.

Circular A-87 states that it is essential that each item of cost be treated consistently in like circumstances as either a direct or an indirect cost.

BFO relies on managers to ensure profiles are up-to-date and did not consistently include the Medicare management code in all employee profiles where the managers had Medicare responsibilities.

If Medicare management codes are not uniformly assigned to cost accounting profiles, the RRB will not be reimbursed for the appropriate share of Medicare direct costs. As a result, we estimate that more than \$19,500 in Medicare management costs were not reimbursed by CMS.

Recommendations

We recommend that BFO:

21. review the cost accounting system employee profiles and ensure that all managers with Medicare responsibilities are appropriately assigned the Medicare management code in their employee profiles;
22. ensure that Medicare management costs are consistently reported in accordance with A-87;
23. determine the correct Medicare direct labor reimbursement amount using the compliant employee profiles; and
24. work with CMS to determine, adjust, and correct any erroneous reimbursement of Medicare management costs beginning with fiscal year 2010 to current.

Management's Response & Our Comments

Recommendations 21 and 22: RRB management concurred with these recommendations and estimated the completion date as April 28, 2017.

Recommendations 23 and 24: RRB management did not concur with these recommendations, which were aimed at reconciling the RRB's Medicare management costs. RRB's response stated that although the draft report informed the agency of potential reimbursement under or overstatements and asserted that the agency is not following regulatory requirements and not establishing a cost allocation methodology as prescribed, its response to recommendation 2 clarifies the agency's compliance. RRB management also stated that the audit report does not provide explicit reference to actual reconciled data supporting estimates and projections over the period audited from 2010 through 2014. Additionally, the analysis used to make projections was not supported by statistically valid sampling methods.

RRB management's responses did not meet the intent of these recommendations and appear to contradict its concurrence to recommendations 21 and 22. After the Medicare management codes are properly assigned, RRB will need to determine the correct Medicare direct labor reimbursement amount using the compliant employee profiles. The RRB will also need to work with CMS to determine, adjust, and correct any erroneous reimbursement of Medicare management costs beginning with fiscal year 2010 to current.

Cost Accounting System Includes Profiles for Former Employees

Our audit found the RRB did not delete former RRB employees from the cost accounting system even though RRB managers reviewed employee profiles on a quarterly basis. For example, employee profiles for those who left the RRB were not deleted for almost one year.

RRB's accounting procedures guide stated that RRB employee profiles are to be reviewed and adjusted as necessary by supervisors.

During our fieldwork, BFO officials stated it is not possible for the RRB to remove the employee profile from the cost accounting system because it is controlled by General Services Administration. However, during our exit conference, BFO officials clarified that it is possible for the timekeepers to remove the profiles from the system. These officials believe that the misinformation resulted from a lack of awareness and training of RRB timekeepers and system managers, including BFO. BFO stated they would take action to remove former employees from the cost accounting system.

Until the RRB establishes procedures regarding outdated profiles and trains timekeepers and managers accordingly, former employee profiles will remain in the cost accounting system. As a result, managers will unnecessarily review these profiles as part of their quarterly reviews.

Recommendations

We recommend that BFO:

25. remove the former employee profiles from the cost accounting system; and
26. conduct training and establish procedures for timely removal of former employees from the cost accounting system.

Management's Response & Our Comments

Recommendations 25 and 26: RRB management concurred with these recommendations. Management's response stated that BFO staff reprogrammed the cost accounting system to exclude former employee profiles in the employee profile update in March 2016. They consider this recommendation closed. Closure of recommendation 25 is pending OIG review and approval of the corrective action that was submitted on June 16, 2016. Their estimated completion date for recommendation 26 is October 31, 2016.



UNITED STATES GOVERNMENT

MEMORANDUMFORM G-115f (1-92)
RAILROAD RETIREMENT BOARD

June 16, 2016

TO: Heather Dunahoo
Assistant Inspector General for Audit

FROM: George V. Govan
Chief Financial Officer/
Senior Executive Officer

SUBJECT: Draft Report – Railroad Retirement Board Did Not Calculate Reimbursable Medicare Costs In Accordance With Federal Requirements

This is in response to your request for comments on the above draft report. Following are comments on recommendations addressed to the Executive Committee and Bureau of Fiscal Operations (BFO).

We recommend that the RRB Executive Committee:**1. Perform a time study of Medicare work performed by all agency staff,**

Concur. When the new HRT2T integrated personnel and payroll system is implemented through a shared service capability and replaces our current systems (i.e., CHRIS and ETAMS), we will survey at the time of transition, all agency personnel to determine what positions and personnel time is direct labor for Medicare. The new system will have enhanced features that will allow the agency to code any agency personnel labor incurred from direct (OP/FS) and indirect (all non-OP/FS bureaus and offices) elements to track direct Medicare work performed within those elements.

Estimated date of completion. 29 Sep 2017.

2. Establish an A-87 compliant and CMS approved personal activity report based system that will ensure the capture and reporting of actual Medicare work performed,

Nonconcur. Currently, the RRB is compliant with OMB A-87 and uses a Multiple Allocation Base method for costs. Although the annual Cost Allocation Plan (CAP) does not explicitly state the methodology, the document explicitly states in section II, subtopic

titled *Methodology*, that the OMB Circular A-87 was used as a guide to develop the CAP. The Multiple Allocation Base method is explicitly displayed in supporting schedules and exhibits. Additionally, the schedules and exhibits identify procedures used to develop cost reimbursement for Medicare.

As stated in response to recommendation #1, the transition to an enhanced integrated personnel and payroll HRT2T shared service provider system will meet the secondary part of this recommendation to capture and report actual Medicare work performed.

3. Update the RRB employee direct labor profiles to represent actual work performed based on an A-87 compliant system methodology.

Nonconcur. See response to recommendation #2.

We recommend that Bureau of Fiscal Operations:

4. Adopt and implement A-87 as an agency requirement,

Nonconcur. See response to recommendation #2.

5. Work with CMS to update the Medicare interagency agreement and establish procedures for maintaining and updating the agreement,

Concur. Estimated completion date: 29 Sep 2017.

6. Reevaluate the RRB's cost allocation plan and implement an A-87 compliant methodology for future Medicare direct labor costs using appropriate specialists and expertise,

Nonconcur. See response to recommendation #1 and 2.

7. Utilize and maintain A-87 compliant personal activity reports and employee certifications through authorization by the RRB's Executive Committee to ensure that reimbursed Medicare direct labor costs represent costs for actual and allowable Medicare work performed,

Nonconcur. See response to recommendation #2.

8. Work with CMS to determine, adjust, and correct any erroneous reimbursement of Medicare direct labor costs beginning with fiscal year 2010 to current based on actual work performed,

Nonconcur. Although, the draft report documents analysis to inform the agency of potential reimbursement under or overstatement, the report asserts that the agency is not following regulatory requirements and not establishing a cost allocation methodology as prescribed in regulation cited. The response for recommendation #2 clarifies the

agency's compliance. Next, the audit report does not provide explicit reference to actual reconciled data (i.e, quantified results) supporting estimates and projections over the period audited from 2010 through 2014. Additionally, the analysis documented in the report used to make projections was not supported by statistically valid sampling methods to provide decisive reference to such for potential under or overstated reimbursements.

9. Develop and certify an indirect cost methodology and rate that complies with A-87 using appropriate specialists and expertise,

Nonconcur. See response to recommendation #2.

10. Obtain CMS approval for the indirect cost methodology and rate developed based on the recommendations in this report,

Nonconcur. See response to recommendation #2. Additionally, for each year examined in the audit report, we have received CMS's signed acceptance and approval of the CAP.

11. Determine the correct Medicare indirect cost reimbursement amount for fiscal years 2010 to current using the compliant indirect cost rate for the period,

Nonconcur. See response to recommendation #2 and #8. BFO staff will continue to strengthen validation processes by including statistical valid sampling of profiles until we transition to HRT2T shared service provider system, which will provide direct tracing for Medicare costs.

12. Establish procedures requiring annual certification of the cost allocation plan and indirect cost rate prior to reimbursement that complies with A-87,

Nonconcur. See response to recommendation #2.

13. Establish a variance analysis control process that will help to identify indirect cost reimbursement miscalculations and ensure timely corrective action,

Nonconcur. The methodology used in the audit report is not evident. Additionally, the percentage change calculations compare changes year to year, which discount the impact of cost pool changes (the base for determining direct and indirect percentages) within the year.

14. Submit a detailed indirect cost rate proposal in support of its allowable and allocable indirect labor costs to CMS for approval prior to reimbursement,

Nonconcur. See response to recommendation #10.

15. Work with CMS to determine, adjust, and correct any erroneous reimbursements resulting from the allocation of all of the RRB's indirect labor and non-labor costs beginning with fiscal year 2010 to current,

Nonconcur. See response to recommendation #8.

16. Conduct a thorough investigation and determine if the Purpose Statute and/or Anti-deficiency Act was violated as a result of the RRB's Medicare reimbursement process and report violations in accordance with OMB Circular A-11,

Nonconcur. See response to recommendation #2 and #8.

17. Revise their cost allocation plan procedures to include: (1) an explanation and rationale for its plan methodology; (2) the development of an indirect cost rate; (3) certification requirements and instructions; and (4) succession and contingency planning for the role of preparing the plan,

Concur. Estimated completion date: 28 Apr 2017.

18. Conduct training to ensure the cost allocation plan is reviewed and approved by the RRB's Board members as required,

Concur. Estimated completion date: 28 Apr 2017.

19. Obtain all necessary training on the requirements of federal interagency agreements and A-87 in order to properly prepare and submit its Medicare cost allocation plan,

Concur. Estimated completion date: 28 Apr 2017.

20. Establish and implement quality control mechanisms to ensure the accuracy of the cost allocation plan reporting and reimbursed Medicare costs,

Concur. Estimated completion date: 28 Apr 2017.

21. Review the cost accounting system employee profiles and ensure that all managers with Medicare responsibilities are appropriately assigned the Medicare management code in their employee profiles,

Concur. Estimated completion date: 28 Apr 2017.

22. Ensure that Medicare management costs are consistently reported in accordance with A-87,

Concur. Estimated completion date: 28 Apr 2017.

23. Determine the correct Medicare direct labor reimbursement amount using the compliant employee profiles,

Nonconcur. See response to recommendation #8.

24. Work with CMS to determine, adjust, and correct any erroneous reimbursement of Medicare management costs beginning with fiscal year 2010 to current,

Nonconcur. See response to recommendation #8.

25. Remove the former employee profiles from the cost accounting system,

Concur. BFO staff reprogramed the cost accounting system to exclude former employee profiles in the employee profile update in March 2016.

We consider this recommendation closed.

26. Conduct training and establish procedures for timely removal of former employees from the cost accounting system,

Concur. Estimated completion date: 31 Oct 2016.

If there is any additional information you need, please advise me.

cc: Executive Committee
Director of Audit Affairs and Compliance
Chief of Accounting and Budget Division