ASTHO Island Areas Workgroup

October 2024

Implementing Indirect Cost Rates in Island Jurisdictions: Best Practices and Resources

Health agencies play a pivotal role in advancing public health initiatives and improving community health outcomes. To maximize their impact, a health agency must be able to efficiently manage grants from HHS and other funders. Agency leadership and grants staff can use indirect cost rates (ICRs) to strengthen infrastructure around grants management and other cross-cutting administrative functions. This guide summarizes best practices and helpful resources related to indirect cost recovery in governmental public health.

Best Practices for Successfully Implementing ICRs

1. **Prioritize building internal subject matter expertise related to federal grant regulations.**
    - Grant staff must possess a thorough understanding of federal regulations governing indirect cost recovery, including the Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (Uniform Guidance). For health-related grants, health agency staff must also understand HHS's version of the Uniform Guidance, 45 CFR 75. Links to both of these are included at the end of this document.
    - It is important to stay up to date on changes in federal regulations and to adapt indirect cost recovery approaches accordingly to align with evolving requirements. For example, updates to the Uniform Guidance will go into effect on Oct. 1, 2024, and may include (as of August 2024) an adjustment of the de minimis rate from 10% to 15%. Grants staff are waiting to see if and how HHS' 45 CFR 75 language will address this and other updates.
    - Invest in targeted capacity-building initiatives to enhance the proficiency of staff involved in grants management and financial reporting. Leverage external subject matter experts to help build capacity and foster a culture of continuous learning and skill development.

2. **Before obtaining a federally negotiated ICR, develop a comprehensive cost allocation plan that outlines how your agency will distribute indirect costs across programs or projects.**
   a. All good cost recovery begins with good cost identification processes. Costs must be identifiable in agency accounting systems, and agencies must have the ability to organize costs by function and decouple line items from functions. Ensure all funding sources are identified, including private sources, and that there are processes for identifying unallowable costs and irregular costs (e.g., atypical staffing arrangements, costs incurred outside the accounting system).

      ii. An agency's chart of accounts must be specific to ensure proper coding of costs in the accounting system and no double entries; for example, a "supplies" code might need to be broken down into categories like "utilities," "generic office supplies," and "programmatic supplies."

      iii. Often, the best place to find detailed information about unallowable and irregular costs is 2 CFR 200 (not your Notice of Award).

   b. Utilizing allocation bases such as direct labor hours, square footage, or personnel count ensures equitable and transparent allocation practices.

   c. You can learn more about allocation plans and processes via the resources at the end of this document.

3. **Build meticulous documentation processes, as well as clear timelines, roles, and responsibilities among staff responsible for applying for and reporting on the ICR. This information will also help you to evaluate the impact of your ICR.**

   a. Maintaining meticulous documentation is essential to substantiate indirect cost calculations and allocation methodologies. Rigorous documentation fosters compliance and transparency, and facilitates efficient audits and financial reporting processes.

   b. Agencies should adhere to the indirect cost proposal submission deadlines outlined in federal regulations, thereby ensuring timely review of their ICR applications and adherence to federal reporting requirements.

   c. Regularly evaluate your ICR and the processes around it: Is this rate meeting program / agency needs? Are ICR processes (in your agency, in the local government, with funders) promoting efficient and sufficient cost recovery? Regular evaluation will facilitate iterative improvements to keep your cost recovery as effective as possible.

4. **Develop strong relationships with the agencies who support ICR application and implementation.**
    a. Health agencies rarely control their ICR; oftentimes, health and finance agency staff must work collaboratively with staff from partner administrative agencies to define equitable and timely indirect cost recovery mechanisms.

    b. Foster open communication channels and transparent dialogue with the departments responsible for negotiating ICRs. You may wish to improve various health and financial agency staff's understanding of program operations, funding dynamics, and local/federal regulatory nuances across the various agencies involved in ICR processes.

5. **Do not compare your ICR value with other agencies' ICR values. That said, it may be valuable to compare ICR structures and methodologies.**
    a. Unless you have the same methodology, ICR values will not be comparable across different jurisdictions. Methodological considerations include how expenditures are treated, which ICR proposal methodology was adopted, the relationship between the current conditions and conditions at application, the factors included in the rate's denominator, and the breakdown of funding streams represented in the application.

Commonly Asked Questions About ICRs

1. **What does my agency do with an expired ICR?**
    a. The goal is to maintain a current, non-expired ICR at all times. That said, if your jurisdiction's ICR expires, there is no formal process that defines how to handle this. Negotiated rates typically remain effective for the organization's fiscal year, and the absence of a new rate means effectively no rate is in place. The feasibility of continuing to use an expired rate depends on the policies of each federal awarding official/agency.

2. **Can my agency use a de minimis rate? For how long?**
    a. Please see 2 CFR 200 for information about de minimis rates. The Island Areas Workgroup (IAW) Health Financing Subgroup's 2023 report "Improving Indirect Cost Rate Use in Island Jurisdictions" also provides information on eligibility requirements for de minimis rates. A general rule of thumb is entities that receive more than $35 million in direct federal funding are not eligible to utilize a de minimis rate.

    b. For entities eligible to use the de minimis rate, there is no formal application process beyond stating the request to each federal awarding official. At present, this rate allows entities to charge 10% of modified total direct costs indefinitely without documentation or negotiation.

3. **Can my agency have more than one ICR? Should my agency have more than one ICR?**
    a. While it is possible to maintain more than one ICR, the IAW Health Financing Subgroup's recommendation to island financial leadership is to prioritize perfecting the use of one ICR before seeking to establish multiple ICRs. There are situations in which having multiple ICRs may be valuable, like when a subsection of grants maintains a higher proportion of indirect costs (e.g., those associated with a particular administrative structure or topical area) and would benefit from a specialized ICR. (e.g., those associated with a particular administrative structure or topical area) and would benefit from a specialized ICR.

4. **My agency always receives its ICR late. Is there anything I can do to improve the timeliness of receiving my agency's ICR?**
    a. This question is relevant only for federally negotiated ICRs; de minimis rates do not require an application or the associated timelines for review/approval.

    b. Ensure your agency is on a three-year carryforward cycle to give you the maximum amount of time to complete audits and incorporate actual costs into the next ICR proposal. See Figure 1 for an example of the timelines associated with a three-year carryforward cycle.

Figure 1: *Example of a Three-Year Carryforward Cycle*

Fiscal year (actual costs): January 2023 – December 2023
Proposed rate year (three-year carryforward cycle): January 2026 – December 2026

2023 Audit due date:	September 2024	→ Nine months to approve 2026 budget and prepare/submit ICR proposal
2026 Proposal due date:	June 2025	
Negotiation/rate issue:	July – December 2025	→ Six-month window

    c. There is no official application open period for ICR proposals; proposals are accepted at any time and processed in a "first come, first serve" manner. Submitting a proposal six months prior to the next fiscal year increases the likelihood of having a negotiated ICR by the start of the new fiscal year. If an audit is completed within nine months after the end of the fiscal year, the only factor delaying the next proposal submission (due in nine months) would be the budget approval for the proposed rate year. Entities with internal processes requiring budget approval within the six-month window before the fiscal year's start may experience delayed submissions and potentially late negotiated rates.

5. **What should I do if project officers from the same grantor agency differ in how they interpret regulations related to expired ICRs or other elements of grant policy?**
    a. The grant specialist—not the project officer—is ultimately in charge of how funds are structured for a given grant. If you have questions about grant policy, talk to the grant management official noted in your Notice of Award.

    b. Grant policies may vary between agencies, centers/departments, or even grants within a center. It's important to clarify the regulations affecting each of your grants!

6. **Can my agency hire a contractor to lead our ICR application?**
    a. Yes. In the past, some island agencies have hired a contractor to support the collection of information necessary for the ICR application, though the appropriate agency within the jurisdiction government (e.g., department of finance) leads the actual application process. Please note that if your cognizant agency is the U.S. Department of the Interior, any contractor you choose must reach out to DOI (e.g., a letter on company letterhead signed by the organization's Chief Executive) to confirm the contractor's capacity to conduct the work in compliance with DOI standards.

Resources

1. Improving Indirect Cost Rate Use in Island Jurisdictions by the IAW Health Financing Subgroup—for data on how island health agencies currently utilize ICRs.
2. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards (2 CFR Part 200).
   a. The subgroup particularly recommends Section 414, "Indirect (F&A) costs."
3. The Uniform Administrative Requirements, Cost Principles, and Audit Requirements for HHS Awards (45 CFR Part 75).
   a. The subgroup particularly recommends the cost allocation guidance in 45 CFR Part 95.501-519, "General Administration—grant programs (public assistance, medical assistance, and state children's health insurance programs)."
4. A Guide for Indirect Cost Rate Determination by the U.S. Department of Labor—for guidance on how to establish an ICR.
5. The DOI Indirect Cost Rate Negotiation Services website by the Interior Business center—for templates, sample proposals, FAQs, and other helpful resources.
6. The National Association of State Auditors, Comptrollers, and Treasurers News webpage—for updates on federal financial management, auditing, and grants.
7. Grants Management Office Structure Optimization Toolkit by ASTHO—for guidance on optimizing grants management office structures for more efficient and effective operations.

ASTHO support for the Island Areas Workgroup is supported by the Centers for Disease Control and Prevention, Center for State, Tribal, Local, and Territorial Support (CSTLTS), Office of Island Affairs (OIA), under Cooperative Agreement OT18-1802 Strengthening Public Health Systems and Services through National Partnerships to Improve and Protect the Nation's Health. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC or the other organizations involved nor does the mention of tradenames, commercial products, or organizations imply endorsement by the U.S. Government.