



# Improving Indirect Cost Rate Use in Island Jurisdictions

Island Areas Workgroup,  
Health Financing Subgroup

# Executive Summary

Indirect cost rates (ICRs) are a critical component of effective financial management and cost allocation systems and processes. These processes support the efficient management and spenddown of federal funds. Indirect costs are expenses that are not easily attributable to one specific contract, grant, or project within an organization. Direct costs are expenses connected to a specific contract, grant, or project. ICRs are valuable because they allow recipients to allocate shared administrative costs across all grant program areas, thereby achieving cost savings and supporting salaries for cross-cutting staff. Establishing and maintaining ICRs poses substantial advantages to public health agencies but also requires a significant time investment, strong accounting practices, and a robust grants management infrastructure.

The eight U.S. Island jurisdiction health agencies—Puerto Rico (PR), the U.S. Virgin Islands (USVI), Guam, the Commonwealth of the Northern Mariana Islands (CNMI), American Samoa, the Republic of Palau, the Republic of the Marshall Islands (RMI), and the Federated States of Micronesia (FSM)—face unique grants management challenges inherent to their small populations and remote geography. These include limited staffing, smaller grant volumes, and smaller local treasuries. These factors contribute to territorial and freely associated state (T/FAS) government agencies' historical challenges in efficiently managing and spending down federal funds. Often, Island jurisdictions do not utilize ICRs optimally.

A December 2022 ASTHO survey of island health financing staff found that six island health agencies utilize an ICR. Five (PR, USVI, Guam, American Samoa, and Palau) use a federally negotiated rate and one (CNMI) uses a de minimis rate. RMI was in the process of implementing a de minimis rate at the time of survey; FSM does not utilize an ICR. Survey results show consistent challenges in island ICR implementation, with several jurisdictions acknowledging lapsed ICRs and inconsistent ICR application.

Island health financing staff defined the most common challenges associated with island ICR use as (1) the lack of health agency control over ICR funds, (2) grant ICR caps, (3) unclear or inconsistent ICR guidance, and (4) slow ICR processes. Partners also highlighted foundational challenges within current island accounting and financial management systems, as well as infrastructure challenges inherent to small island government systems (e.g., recruitment and retention challenges, high costs of doing business, small treasuries). Combined, these factors contribute to limited ICR utilization and reduced financial absorptive capacity in T/FAS health agencies. ICRs are one tool to improve sustainable health financing and ensure core operational expenses are covered. These, in turn, improve health agency spenddown and strengthen grants management.

All eight Island jurisdictions have existing policies and financial systems that could support steps to improve ICR utilization. Federal, island, and nonprofit partners should prioritize efforts to enhance T/FAS implementation of ICRs to promote improved public health administration and planning. This report recommends several actions through which island health financing staff, federal partners, and nonprofit partners can strengthen island financial management structures and promote uptake of ICRs, which include:

- Clarifying and standardizing internal HHS agency policies related to ICR implementation (including but not limited to consistency across and within HHS-Operational Divisions, especially within the same programs).
- Strengthening island interagency collaboration on ICR-related processes.
- Increasing technical assistance and capacity building for sustainable health financing, including the use of ICRs to cover core operating expenses.

## About the Report / Acknowledgments

Established in October 2021, ASTHO's Island Areas Workgroup (IAW) brings together representatives from island jurisdictions, federal agencies, and trusted partners to address key administrative challenges that impact health outcomes in island jurisdictions, including efforts to strengthen procedures and organizational policies affecting health financing, data capacity, and workforce development. The U.S. Island jurisdictions include five territories and three freely associated states. <sup>1</sup>

The Health Financing Subgroup submits this report to the IAW as a tool to guide future efforts to improve T/FAS' use of ICRs.

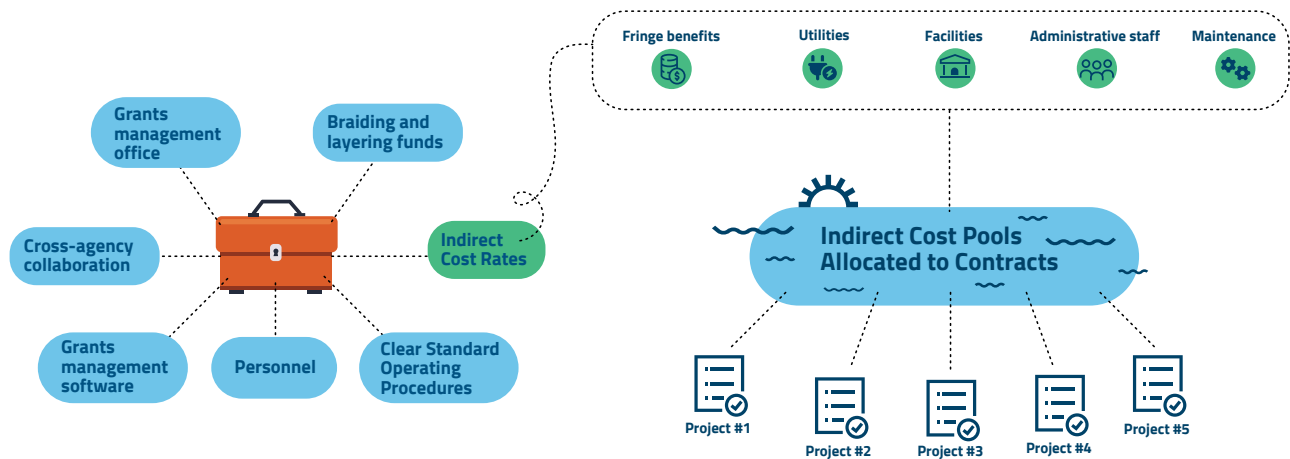
The IAW Health Financing Subgroup thanks Emi Chutaró and Vince Camacho for their leadership of the subgroup. Additional thanks go to all subgroup members for their time and input, especially Tatia Monell-Hewitt, David Johnson, and ASTHO staff Dulce Mendoza and Alex Wheatley.

---

1) Territories: Puerto Rico, the U.S. Virgin Islands, Guam, the Commonwealth of the Northern Mariana Islands, American Samoa. Freely associated states: Palau, the Marshall Islands, and the Federated States of Micronesia.

## Figure 1. The value of an indirect cost rate

*A strong financial management framework requires many different tools, processes, and human resources. Together these components allow an efficient spenddown of funds.*



## Introduction

In support of preventing disease spread, reducing health inequities, and promoting optimal health for all, public health agencies must be able to manage and spend down grant funding. Territorial and freely associated state (T/FAS)<sup>2</sup> health agencies face unique grants management challenges inherent to their small populations and remote geography, such as limited staffing, smaller grant volumes, and smaller local treasuries. These factors contribute to T/FAS government agencies' historical challenges in efficiently managing and spending down federal funds.

Direct costs are expenses connected to a specific contract, grant, or project. Examples of direct costs include project staff time, project travel expenses, and project-specific equipment or supplies.

Conversely, indirect costs are expenses that are not easily attributable to specific contracts, grants, or projects. Examples of indirect costs include rent, shared supplies, utilities (e.g., electricity), and some cross-cutting personnel (e.g., administrative and finance staff, executive leadership). Direct and indirect cost categories may vary slightly across health agencies, depending on how functions are defined across the health system.

In general terms, an indirect cost rate (ICR) is an equitable, standardized method through which organizations can allocate shared indirect costs. Formally, it is the ratio between the total indirect costs and the benefitting direct costs. ICRs allow health agencies to use funds to pay for shared administrative functions common to all agency functions that include maintaining shared office space, buying data systems to support efficient grant management, achieving cost savings for bulk supply orders, and supporting staff salaries for cross-cutting roles like grants management and human resources. ICRs allow agencies to streamline shared costs and efficiently allocate funds to support critical administrative and operational functions like rent, utilities, maintenance, cross-cutting personnel, agency systems, and grants management staffing.

Currently, there are two types of ICR available to health and other social service agencies. A de minimis rate is a default 10% ICR, while a federally negotiated rate is determined by the agency's cognizant federal agency (e.g., HHS and the U.S. Department of the Interior for island jurisdiction health agencies). Organizations should consider both types since the best ICR is the one that allows organizations to operate programs without leftover funds and without needing additional funds.<sup>3</sup>

2) These terms will be used interchangeably throughout this report: "territories and freely associated states" (T/FAS), "island jurisdictions," and "island areas."

3) "Indirect Costs Guide Sheet." The Office of Justice Programs Territories Financial Support Center (OJP TFSC). [https://www.ojp.gov/tfsc/indirect\\_costs\\_guide\\_sheet\\_508](https://www.ojp.gov/tfsc/indirect_costs_guide_sheet_508)

*A summary of the key characteristics of each option is below.*

## Negotiated ICR

- The negotiated rate varies to reflect the average breakdown of direct and indirect costs as shown through recent audits. Negotiated ICRs typically range from 5-35%.
- Organizations must apply for a negotiated ICR and receive an indirect cost certification from a cognizant federal agency.
  - The Department of the Interior is the cognizant agency for all departments and agencies in all the island jurisdictions, except for Puerto Rico. HHS is the cognizant agency for the Puerto Rico Department of Health.<sup>4</sup>
- Organizations must prepare and submit the Indirect Cost Proposal no later than six months after the organization's fiscal year-end.
- All islands with negotiated ICRs currently operate on a three-year carryforward cycle, meaning last year's costs create the ICR two years from now (e.g., 2022 rates would use actual costs from FY 2019). See Figure 2 for more information.

## De minimis ICR<sup>5</sup>

- De minimis rate is 10% and the rate may be used indefinitely by eligible entities.
- Organizations must submit the Certification of De Minimis Cost Rate for each program.
  - This process is simpler than submitting an Indirect Cost Proposal.
- Organizations must be eligible to use a de minimis rate under §200.414 Indirect (F&A) Costs.
- Organizations must have never received a federally negotiated ICR for any federal award.
- Organizations must have received less than \$35 million in direct federal funds in the fiscal year the de minimis is requested.
- To obtain a de minimis rate, a health agency must submit the request to each individual federal awarding official. The cognizant agency for indirect costs does not get involved.

**Figure 2. Federally-negotiated ICR application process (three-year cycle)**



4) Federal Agencies Responsible for Cost Negotiation and Audit of State and Local Governments, Republication, 51 Fed. Reg. 552 (January 6, 1986)

5) "Indirect Costs Guide Sheet." The Office of Justice Programs Territories Financial Support Center (OJP TFSC). [https://www.ojp.gov/tfsc/indirect\\_costs\\_guide\\_sheet\\_508](https://www.ojp.gov/tfsc/indirect_costs_guide_sheet_508)

The purpose of an indirect cost rate is to facilitate the allocation and billing of indirect costs. Approval of the indirect cost rate does not mean that an organization can recover more than the actual costs of a particular program or activity. If direct funds are not expended, then indirect costs would not be charged.

ICRs vary significantly across different types of organizations. Most interpret the Uniform Guidance to set forth the de minimis rate of 10% as a healthy minimum for indirect costs associated with efficiently implementing federal grant programming. A 2020 study by the MacArthur Foundation found that the minimum ICR associated with financially healthy nonprofit organizations is 29%.<sup>6</sup> A 2016 study found that nonprofit ICRs range from 21-89%, with a median of 40%.<sup>7</sup> A commonly cited figure states that ICRs often range from 18-35%.<sup>8</sup>

A 2021 ASTHO query of 15 state health agencies showed that indirect cost rates vary significantly. Among state health agencies with one indirect cost rate in use for all health grants, rates ranged from 14.7% - 34.6% with an average of 23.2%. For state health agencies with multiple indirect cost rates in use across their agency, rates ranged from 4.5% - 30.5%. States often maintained separate indirect cost rates for subawards.

Anecdotally, many of the U.S. Island jurisdictions' health agencies do not fully utilize ICRs and/or encounter significant challenges when trying to use ICRs. An agency that fully utilizes an ICR would leverage its de minimis or negotiated ICR to achieve efficient and optimally cost-effective operations. This report seeks to define current ICR utilization within these island areas, including key challenges and enabling financial management infrastructure.

The report concludes with recommendations for improving ICR utilization in the T/FAS.

## Current Island ICR Utilization

As of December 2022, six islands utilize an ICR, of which five (PR, USVI, Guam, American Samoa, and Palau) use a federally negotiated rate and one (CNMI) uses a de minimis rate. One jurisdiction (RMI) was in the process of establishing its de minimis rate at the time of survey and had not yet successfully implemented it in all health grants. One jurisdiction (FSM) does not utilize an ICR. Among T/FAS with an ICR, rates vary from 5.4% to 20.7%, with an average of 13.9%. This average is significantly lower than the average of state health agencies with one indirect cost rate who responded to ASTHO's 2021 survey (23.2%). It is interesting to note that two islands—Puerto Rico (5.4%) and Palau (8.13%)—maintain a federally negotiated ICR that is less than the de minimis rate of 10%.

All islands with indirect cost rates report using these rates on all health grants. Multiple island jurisdictions reported having an expired ICR at the time of the survey. Guam, Palau, American Samoa, USVI, and Puerto Rico use the indirect cost rate negotiated by the jurisdiction's central government. CNMI utilizes a de minimis rate for the health agency, separate from the federally negotiated rate of the CNMI government; this separation enables the agency to use a de minimis rate, as the agency receives less than \$35M in direct federal funds and has never been issued a federally negotiated indirect cost rate.









---

6) "Indirect Cost Rate Policy." MacArthur Foundation. <https://www.macfound.org/about/our-policies/indirect-cost-policy/>

7) Michael Etzel and Sridhar Prasad. "Pay-what-it-takes Philanthropy." The Bridgespan Group. <https://www.bridgespan.org/insights/pay-what-it-takes-philanthropy>

8) "Indirect costs in nonprofit contracts with government: OMB Uniform Guidance", Nonprofit Overhead Toolkit, CalNonprofits. <https://calnonprofits.org/programs/overhead/toolkit/indirect-costs>

**Figure 3.**

Jurisdiction	Utilize an ICR?	Type of ICR	Cognizant Federal Agency
Puerto Rico 	Yes	Negotiated (5.4%)	HHS *
USVI 	Yes	Negotiated (19.8%)	DOI
Guam 	Yes	Negotiated (20.7%)	DOI
American Samoa 	Yes	Negotiated (19.3%)	DOI
CNMI 	Yes	De minimis (10%)	DOI
RMI 	Yes	N/A, with plans to implement a de minimis (10%)	DOI
Palau 	Yes	Negotiated (8.1%)	DOI
FSM 	No	N/A	DOI

\* HHS is the cognizant federal agency for the Puerto Rico Department of Health.

DOI is the cognizant federal agency for the Governor's Office.

## Island ICR Challenges

Island jurisdictions encounter significant challenges when trying to utilize ICRs, which stem from barriers at the levels of health agency, island government, and federal government. This section aims to highlight the key challenges shared by island financial staff during IAW health financing subgroup meetings and through the December 2022 ICR survey.

In many ways, island health agencies are an ideal environment in which to assess and optimize ICR procedures. With proportionally fewer staff and comparatively underdeveloped grants management infrastructure than their contiguous-states counterparts, island health agency staff often have a hands-on role managing the financial components of multiple grants. In doing so, they may have more

exposure to the variety in federal ICR policies than do most state health agency staff. Island staff's unique perspective on a cross-section of grant rules gives them unique insights into how federal ICR policies impact program implementation and opportunities to optimize ICR infrastructure.

In assessing the challenges below, it is important to understand how unique characteristics of island health agency infrastructure impact grants management and ICR implementation. Islands' small populations and isolated geographies impede recruiting and retaining key health, financial, and management staff. These factors also translate to higher costs of doing business and smaller national treasuries, which undermine jurisdictions' ability to upfront grant costs. T/FAS' sovereign or semi-sovereign status introduces additional levels of bureaucracy through which awarded funding must

pass before it can be spent, which can negatively impact spenddown. Lastly, time zones (UTC+ 12 to 16 hours for most of the Pacific) and language barriers (Spanish is the working language of Puerto Rico) can impede access to and use of external technical assistance to address grants management challenges. These factors vary across each island, but broadly shape grants management challenges across the region.

According to ASTHO's December 2022 survey, the most common challenges associated with T/FAS ICR utilization are:

### **1. Health agencies often lack control over ICR processes and funds.**

- In most island jurisdictions, ICR negotiations are outside the control of health agencies. Ministries of Finance or Treasury often lead ICR processes, including application and funding allocation across the government. When indirect cost revenues are centralized within the government, health agencies may experience a lag in receiving ICR funds. The central government may also choose to allocate ICR funds from health programs to other priorities, thus reducing the available ICR funding for health programs and the divisions that manage them.
- In small island jurisdictions, some formula grants are received with such minimal amounts that if the central government takes a percentage out for indirect costs, it leaves a very minimal amount for effective program implementation.

### **2. Grants can cap the amount of funding eligible to be spent on indirect costs.**

- Some grants cap the percentage of funding recipients can set aside for indirect costs to ensure grant funding directly translates into program activities. However, as stated earlier in this report, ICRs help promote more effective and efficient programming:

they support cross-cutting functions integral to the successful management, implementation, monitoring, and reporting of program activities. In large state health agencies with strong grants management infrastructure, one grant's ICR cap will have minimal impact on program functioning. However, in small island health agencies, economies of scale and geographic isolation contribute to significantly higher costs for supplies, shipping, and travel. Also, smaller populations typically lead to smaller grant awards. Because T/FAS see small grant awards and high costs, capped ICRs can have an outsized negative impact on program function.

### **3. Islands often lack sufficient ICR guidance and may experience inconsistencies in how grantors implement ICR regulations.**

- Rules around ICR utilization can vary significantly across grants, program areas, and federal agencies, as well as across jurisdiction governments. In addition, there can be significant variation in implementing standard agency ICR policies at the project officer level. For example, jurisdictions provided five different answers when asked for the proper protocol for an expired indirect rate. The confusion stems from multiple levels: federal policy may not be known, island policy may not be clear, and implementation may vary. For example, jurisdictions have experienced instances in which two project officers from the same agency and program area, with the same federal guidelines, differed in their response to an expired indirect ICR: one project officer approved its continued use while the other did not. There is a need for greater clarity and predictability in how federal ICR policies will take shape at the program level.
- Some islands also highlighted challenges associated with a lack of guidance within health agencies that can guide programmatic staff in collecting the data necessary for ICR planning, budgeting, and utilization.



#### 4. ICR processes may not be completed in a timely manner.

- An ICR proposal is due within six months of the end of the fiscal year, and ICR proposals are reviewed and processed in the order they are received. Island jurisdictions must submit current audit data to complete an ICR proposal. However, the deadline to complete an audit is within nine months of the end of the fiscal year. If a jurisdiction takes nine months to complete the audit, it will meet its financial obligations but be last in line to receive an ICR. In this case, a jurisdiction may receive an ICR that is good only for a short time before it needs to be renewed again. If a jurisdiction cannot complete an audit within nine months, it cannot submit an ICR proposal, and the existing ICR may lapse. Jurisdictions often experience challenges with expired ICRs.

The combination of these ICR challenges along with the infrastructure challenges inherent to small island government systems (e.g., severe workforce challenges, high costs of doing business, small treasuries) contribute to limited ICR utilization and reduced financial absorptive capacity in T/FAS health agencies. ICRs are one tool to improve a health agency's ability to fund its core operational expenses, spenddown grant funding, and strengthen financial management.

## Island ICR Infrastructure

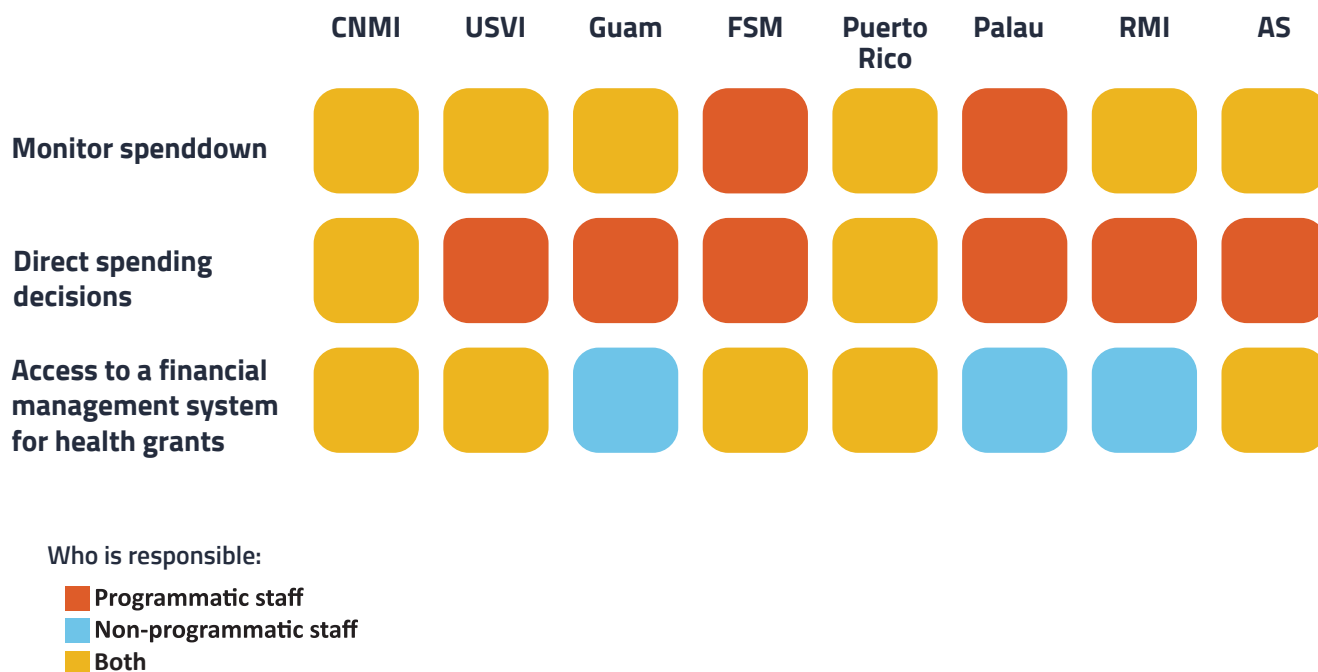
To implement an ICR, a jurisdiction must have robust cost allocation processes. These can include policies, procedures, and systems that identify and track indirect versus direct costs. Health agencies must also collaborate with sister agencies involved in the functions necessary for ICR development and implementation, such as accounting and human resources. Many different types of staff are involved in ICR-related tasks: for example, project directors shape budgets, project staff spend funds in adherence with federal guidelines, and grants management staff monitor spenddown. In this way, ICR processes are influenced by the broader business systems that shape grants management within each island.

To understand ICR infrastructure within each island, ASTHO's 2022 survey gathered information on the policy authorities, staff responsibilities, and agency procedures influencing ICR utilization. In this report, key functions required for ICR utilization were defined as:

- Developing federal grant budgets.
- Developing health-related financial or grants management policies.
- Updating health-related financial or grants management policies.
- Staff access to a financial management system for health programs.

The sections below summarize trends in T/FAS financial systems and how each may influence efforts to improve ICR utilization. This section is intended to draw attention to shared themes, not highlight the strengths or weaknesses in any given jurisdiction. For more detail on each island's ICR infrastructure, see Appendix A.

**Figure 4. Breakdown of primary responsibilities for ICR-related processes:**



**1. Efforts to improve ICR utilization will require engagement from T/FAS health and finance agencies.**

Health-related financial management responsibilities are often split across health agencies and finance/treasury agencies (e.g., Ministry of Finance, Office of Management and Budget). Health agencies often lead the development of federal health grant budgets:

- In six of eight jurisdictions, health agencies are the primary lead for this function.
- In two islands, this function is equally split across the health agency and an administrative or budget agency.

Health agencies and finance agencies are more equally involved in developing and updating health-related budgetary or grants-management policies:

- Five health agencies lead the development of health-federal grant budgets.
- Two jurisdictions have health and finance agencies jointly develop the budgets.
- In one jurisdiction, the finance agency leads budget development.

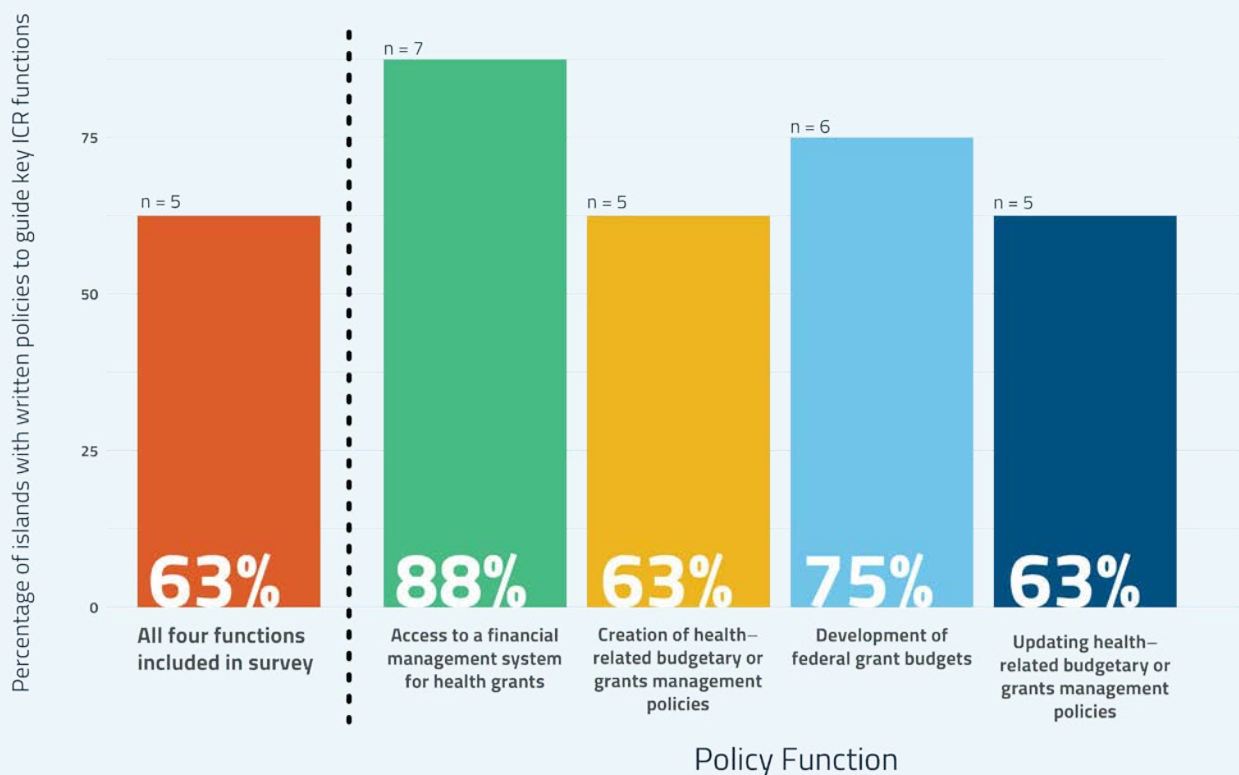
Access to a financial management system for health grants is most commonly reserved for the finance agency, with the finance agency leading access in four jurisdictions, finance and health jointly coordinating access in three agencies, and health agency directing access in one jurisdiction. Island health financing staff note that it is difficult for one agency to effect major change in ICR processes. Executive leadership and cross-agency collaboration is required, especially if health agencies have only limited access to the financial systems and other agencies have greater oversight on the jurisdiction’s government finances.

## 2. Efforts to improve island ICR utilization will affect roles and responsibilities across programmatic and nonprogrammatic staff.

ICR-related responsibilities and authorities span both programmatic (project-specific) and nonprogrammatic (cross-cutting) staff. All islands rely on a mix of both programmatic and nonprogrammatic staff to implement three critical ICR-related functions: monitoring spenddown, directing spending decisions, and accessing financial management systems. In two jurisdictions, programmatic and nonprogrammatic staff are equally involved in each function. In one jurisdiction, the functions are clearly split across programmatic and nonprogrammatic staff, with

no joint responsibility. The other five jurisdictions vary in the division of responsibility across programmatic staff, nonprogrammatic staff, or joint responsibility. Directing spending decisions is more commonly the responsibility of programmatic staff (six jurisdictions) while monitoring spenddown and accessing financial management systems are more commonly shared responsibilities (five jurisdictions). Where monitoring spenddown and accessing financial management systems are not shared responsibilities, monitoring spenddown is in the realm of programmatic staff (three jurisdictions), while access to financial management systems tends to be the role of nonprogrammatic staff (three jurisdictions). A visual breakdown of these responsibilities is available in Figure 4.

**Figure 5. Written Policies to Guide ICR Use**



### 3. Island health agencies may be able to improve ICR utilization by implementing more standardized and comprehensive grants management policies.

Written policies formally define agency authorities and standard operating procedures. These clear guidelines will be important scaffolding for building future ICR infrastructure. Most islands had written policies that addressed a portion of the four key functions assessed in the survey. The breakdown is as follows:

- 63% (n = 5) of islands have a written policy in place for all four functions included in this survey.
- 88% (n = 7) have a written policy to guide access to a financial management system for health grants.
- 75% (n= 6) have a written policy to guide the development of federal grant budgets.
- 63% (n = 5) have a written policy to guide the creation of health-related budgetary or grants management policies.
- 63% (n = 5) have a written policy to guide updating health-related budgetary or grants management policies.

### 4. ICR best practices will require tailoring to fit within each island's financial management system.

Island jurisdictions vary in which financial management system they use and how these systems interface with broader T/FAS government financial management systems. As of December 2022, the eight island health agencies use the following systems: JDE Edwards Financial Management System, AS 400, Fundware, MUNIS system, 4Gov, Bisan, OneSolution, People Soft 8.4, and Puerto Rico Integrated Accounting System.<sup>9</sup> Some islands report using multiple systems across the health agency and broader government.

Most of these financial management systems are enterprise resource planning systems, a type of software that helps organizations manage day-to-day activities across multiple business processes such as accounting, procurement, project management, and compliance. The systems are structured and coded differently and may have different interoperability requirements. It is common that health agencies do not have a voice in the selection process for governmental financial management systems and must use whatever system is implemented, whether or not it meets health agency needs. More information about island financial management systems is available in the appendix.

9) ASTHO does not endorse specific products or software; this list is for informational purposes.

# Conclusion and Recommendations

ICRs can help health agencies sustainably finance agency operations and, in doing so, more efficiently implement and spenddown federal grant funds. By equitably allocating indirect costs across programmatic areas, ICRs allow agencies to streamline shared core operational expenses and support critical cross-cutting administrative functions like grants management staffing. ICR underutilization is shaped by both island and federal

operational challenges. Lessons learned from an assessment of island utilization of ICRs may also inform ICR utilization by similar organizations in the United States (e.g., rural health departments of small non-profit organizations).

The IAW Health Financing Subgroup seeks to promote the uptake and strengthening of ICR structures in island jurisdictions with a long-term goal of improving health financing processes, policies, and infrastructure in the islands. The IAW Health Financing Subgroup submits this report to the IAW with the following recommendations and considerations.

1. HHS and partners should take steps to clarify, standardize, and disseminate in plain language the internal HHS agency policies related to ICR implementation, such as those associated with ICR caps, the use of expired ICRs, and the potential to default to a de minimis rate while waiting for an approved rate.
2. Responsibility for ICR negotiation and maintenance often lies outside the scope of the health agency. Island health agencies should strengthen and clarify jurisdiction interagency policies to support health agencies in establishing and maintaining current (not expired) ICRs, as well as ensuring health-related indirect cost funding streams reach the health agencies.
3. Within ongoing efforts to strengthen grants management in these jurisdictions, partners should offer technical assistance (TA) to strengthen ICR processes, including steps to firmly establish ICRs in FSM and RMI. This TA may target ICR resources available to programmatic staff, policies affecting financial management, staff engagement with financial management systems, and interagency processes around ICR planning, budgeting, and data collection. This TA should be individualized to each jurisdiction and include steps to map authorities for ICR application and implementation across a jurisdiction's relevant government agencies (e.g., health and finance).
4. The federally negotiated ICRs identified in this report (5.4% - 20.73%) are in some instances less than a de minimis rate and on average lower than state health agency ICRs (23.2% versus 13.9%). This merits further research to determine whether these ICRs meet island jurisdiction operating needs. Other knowledge gaps that the Workgroup or partners should pursue include:
  - a. For islands that maintain an ICR, are the current rates sufficient to achieve the desired cost-savings and efficiencies?
  - b. What policies and procedures determine how ICR funds are allocated from central government to health agencies, and how can stakeholders promote an equitable distribution of administrative oversight and equitable access to ICR funds?
  - c. How do ICRs affect grants management within public health agencies, relative to other strategies to increase and optimize operating expenses (e.g., transferring monies from general funds)?
  - d. How do T/FAS trends in health agency ICR infrastructure compare to those of state health agencies?

# Appendix A

This appendix presents abbreviated island survey results. For more information about the survey and island responses, reach out to the ASTHO Island Support Team at [islandsupport@astho.org](mailto:islandsupport@astho.org).

## 1. Island Indirect Cost Rates (as of December 2022)

CNMI	USVI	Guam	FSM	Puerto Rico	Palau	RMI	American Samoa
10%	19.80%	20.73%	N/A	5.4%	8.13%	N/A, with plans for 10%	19.28%

## 2. Top challenges associated with ICR Utilization:

Jurisdiction	Challenge
CNMI	<p>“Grantor agencies not always consistent with the approval of IDC rates”</p> <p>“Some grant awards have limits on the % of IDC allowed”</p>
USVI	<p>“Due to not having a current rate, indirect cost rate cannot be applied to some grants.”</p> <p>“We are not able to collect for overhead cost.”</p> <p>“We do not have any control over the indirect cost rates. We do not receive the funding that we are supposed to receive.”</p>
Guam	<p>“Receiving the approved IC rate nearing end of FY”</p> <p>“Allocation of IC rate is given to various government agencies, however, the use of the IC rate funds is unknown”</p> <p>“Guidance on IC rate eligibility for grants”</p>
FSM	<i>No ICR.</i>
PR	<p>“Ensure that every administrative office provides reliable statistics to ensure appropriate allocations in the Indirect Cost Rate Proposal annually prepared.”</p> <p>“Ensure that any proposal to seek federal funds for special projects must include all expenses necessary to achieve the project goals, including indirect costs as part of their budget.”</p> <p>“Reorganize fiscal offices (Budget, Finance and Grant Management and External Resources) to improve indirect cost planning, budgeting, and collection.”</p>
Palau	<p>“No control of indirect cost rate”</p> <p>“Public Health agencies do not receive indirect cost rate funds. All indirect cost funds go to the Ministry of Finance; Ministry of Public Health does not have access or authority to use funds.”</p> <p>“Expired indirect cost.”</p>
RMI	“Ensuring that programs incorporate the 10% de minimis rate to their budget”
American Samoa	<p>“Not receiving rate in a timely manner”</p> <p>“Indirect money stays in central gov; doesn’t support DOH finance folks or etc.</p> <p>Inconsistency in the rate year to year”</p>

### 3. Presence of written policies to guide key ICR-related processes:

Jurisdiction	CNMI	USVI	Guam	FSM	Puerto Rico	Palau	RMI	American Samoa
Develop federal grant budgets	Yes	Yes	No	No	Yes	Yes	Yes	Yes
Develop health-related budgetary or grants management policies	Yes	Yes	No	No	Yes	No	Yes	Yes
Update health-related budgetary or grants management policies	Yes	Yes	No	No	Yes	No	Yes	Yes
Access to a financial management system for health grants	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes

### 4. Island Financial Management Systems

Financial management systems in public health agencies are complex. Agencies may use multiple systems throughout the course of a transaction, and different agencies (e.g., the Department of Treasury versus the Department of Health) may have different systems. In addition, agencies may have different setups at the state versus local level, and staff access to intra- and interagency systems can vary significantly. An in-depth analysis of these financial systems is beyond the scope of this report. The table below describes the primary system(s) used by each health agency at the time of the initial survey (December 2022). Subsequent outreach has established that CNMI has since switched to the Tyler MUNIS Enterprise Financial Management System, cementing MUNIS the most common financial management system in the islands with use in three of eight jurisdictions. Subsequent outreach also established that the systems below are used across all government agencies in Guam, CNMI, American Samoa, Palau, FSM, USVI, and Puerto Rico. Additional systems may also be used in these jurisdictions.

Jurisdiction	Financial Management System (as of December 2022)
CNMI	JDE Edwards Financial Management System
USVI	Enterprise Financial Management Software powered by MUNIS
Guam	AS400
FSM	Fundware
Puerto Rico	People Soft 8.4 and Puerto Rico Financial Integrated Accounting System (PRIFAS)
Palau	MUNIS system
RMI	4Gov with plans to transition early next year (Jan-Mar) to Bisan
American Samoa	OneSolution



**PROFILE**  
OF STATE AND TERRITORIAL PUBLIC HEALTH

*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.*